

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Balto.

160

(92)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 32

Village or City Beltsville (No. 4819 Delaware Ave St; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Friedrich Abbott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Child

6 DATE OF BIRTH Dec 16, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 22 ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Balto Co

10 NAME OF FATHER Edgar S. Abbott

11 BIRTHPLACE OF FATHER (State or country) Ohio

12 MAIDEN NAME OF MOTHER Sarah J. Kane

13 BIRTHPLACE OF MOTHER (State or country) N. J.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Intormant) Edgar S. Abbott
(Address) 4819 Delaware Ave

15 Filed Jan 8, 1915 J. M. J. Quinn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 7, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1915, to Jan 7, 1915
that I last saw him alive on Jan 7, 1915

and that death occurred on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:

Double Pneumonia
(Duration) _____ yrs. _____ mos. 7 ds.

Contributory (Secondary) Exhaustion
(Signed) John S. Baber, M. D.
Jan 7, 1915 (Address) 4836 Park Heights Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St. Peters DATE OF BURIAL Jan 8, 1915
20 UNDERTAKER Wm. W. Gaultney ADDRESS Robert North Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 4 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County BaltimoreVillage or City Parkville (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Waldemar L Ahl

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE, MARRIED, WIDDED, OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

1 13 1915
(Month) (Day) (Year)

7 AGE

— yrs. — mos. 14 ds. OR — min. ?If LESS than
1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none9 BIRTHPLACE
(State or country)Maryland

PARENTS

10 NAME OF FATHER

August L Ahl11 BIRTHPLACE OF FATHER
(State or country)Europe

12 MAIDEN NAME OF MOTHER

Henrietta M Paulsen13 BIRTHPLACE OF MOTHER
(State or country)Europe

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henrietta M Ahl

(Address)

Parkville Ind

15

Filed

Jan 28 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 27 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 23 1915 to Jan 26 1915that I last saw him alive on Jan 26 1915and that death occurred on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration) — yrs. — mos. 4 ds.Contributory
SecondaryBroncho-Pneumonia(Duration) — yrs. — mos. 4 ds.(Signed) Monie B. Green M. D.Jan 28 1915 (Address) Hamilton Bldg Co

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CASES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St John Cemetery

DATE OF BURIAL

Jan 28 1915

20 UNDERTAKER

Frederick L. Schwan

ADDRESS

Fullerton Ind

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salsman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicaemia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 4 1915
BUREAU, U. S. C.

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162

(S)

1 PLACE OF DEATH
County Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 40

Village or City Perry Hall (No. Belair Road St., Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant Allison

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Unknown 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH January 8, 1915
(Month) (Day) (Year)

7 AGE If LESS than 1 day, hrs.
yrs. mos. ds. min. ?

6 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto. Co. Md.

PARENTS

10 NAME OF FATHER

Guy Allison

11 BIRTHPLACE OF FATHER

Md.

12 MAIDEN NAME OF MOTHER

Maggie Huber

13 BIRTHPLACE OF MOTHER

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Guy Allison

(Address)

Perry Hall, Md.

15

Filed

Apr 23, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 8, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

 , 191 , to , 191 ,that I last saw him alive on , 191 ,and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Still - Born (Duration) yrs. mos. ds.

Contributory

Secondary

(Signed)

Morris B. Green

M. D.

April 14, 1915 (Address) Hamilton, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State, yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

No foetus found , 191

20 UNDERTAKER

ADDRESS

none

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Corticoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rentier wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

APR 17 1915

BUREAU, V. S.

RECEIVED

MAY 6 1915

BUREAU, V. S.

28

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 41

1 PLACE OF DEATH

County Baltimore

Bay View Asylum

Village or City _____ (No. _____) St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sophie Almond

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married.
(Write the word)

6 DATE OF BIRTH _____, 1885
(Month) (Day) (Year)

7 AGE 29 yrs. _____ mos. _____ ds. OR LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) New York.

PARENTS 10 NAME OF FATHER John Steinman
11 BIRTHPLACE OF FATHER (State or country) New York.
12 MAIDEN NAME OF MOTHER Theresa
13 BIRTHPLACE OF MOTHER (State or country) New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records
(Address) Bay View

15 Filed Jan 5, 1915 Miriam Carr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 6, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1914, to Jan. 5, 1915.
that I last saw her alive on Jan. 4, 1915.

and that death occurred on the date stated above, at 6 5/59 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Pulmonalis.

(Duration) Unknown ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F. J. Callahan, M. D.
Jan 5, 1915 (Address) City 26 Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. 7 ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? Unknown
Former or usual residence 2214 Frederick Ave.

19 PLACE OF BURIAL OR REMOVAL Landon Park DATE OF BURIAL Jan 8th, 1915

20 UNDERTAKER Geo. J. Smith ADDRESS 100 N. Fayette

MARGIN RESERVED FOR BINDING

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

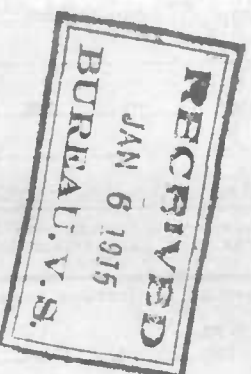
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 164

County BaltimoreVillage or City Bay View Asylum(No. CITY HOSPITAL)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Laura Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH 1.873
(Month) (Day) (Year)

7 AGE 42 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?
It LESS than 1 day, 0 hrs. 0 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Unobtainable
11 BIRTHPLACE OF FATHER (State or country) "
12 MAIDEN NAME OF MOTHER "
13 BIRTHPLACE OF MOTHER (State or country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records
(Address) Bay View

15 Filed Jan 7th, 1915 Miriam Barr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 3rd, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30th, 1914 to January 3rd, 1915.

that I last saw her alive on Jan. 3rd, 1915.

and that death occurred on the date stated above, at 11.45 Pm.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(Duration) 10 yrs. 0 mos. 0 ds.

Contributory Secondary

(Signed) M. D. Phillips, M. D.
Jan. 4th, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 4 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, unknown

Former or usual residence unknown

19 PLACE OF BURIAL OR REMOVAL Johns Hopkins Hos DATE OF BURIAL Jan 7, 1915

20 UNDERTAKER G. L. Hurley ADDRESS 1149 7th Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicemia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental, suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—decident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

165

1 PLACE OF DEATH

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

38

Village or City

Hamilton

(No.)

St.

Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

Anderson son of Charles J. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan 16, 1915
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. OR ____ mo. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Charles J. Anderson

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Anna J. Butler

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore, Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles J. Anderson

(Address)

Hamilton Md

15

Filed

Jan 16, 1915

C. J. Anderson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

Jan 16, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1915 to Jan 16, 1915

that I last saw him alive on Jan 16, 1915

and that death occurred on the date stated above, at 3 1/2 m.

The CAUSE OF DEATH* was as follows:

Atherosclerosis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Atherosclerosis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Henry L. Stry, M. D.

Jan 16, 1915 (Address) Hamilton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore

Jan 17, 1915

20 UNDERTAKER

ADDRESS

Henry Lutz 1007 N. Bond St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac- cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla- ture of the American Medical Association.)

If this certificate is looked over thoroughly and all ques- tions answered in detail, it will prevent further correspon- dence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH 166 | | STATE OF MARYLAND | |
| County Baltimore | | CERTIFICATE OF DEATH | |
| Village or City Beard Creek, off Munan St. | | Registration Dist. No. 44 | |
| 2 FULL NAME Elijah Armstrong | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX Male | 4 COLOR OR RACE Colored | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word) | |
| 6 DATE OF BIRTH June 1, 1869 (Month) (Day) (Year) | | | |
| 7 AGE 45 yrs. 7 mos. 8 ds. OR 1 day. hrs. min. | | | |
| 8 OCCUPATION Farmer (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). | | | |
| 9 BIRTHPLACE (State or country) Ind. | | | |
| PARENTS | 10 NAME OF FATHER John Armstrong | | |
| | 11 BIRTHPLACE OF FATHER (State or country) Ind. | | |
| | 12 MAIDEN NAME OF MOTHER Not known | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) Not known | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Elana Armstrong (Address) Sparrow Point, Md. | | | |
| 15 Mar. 21, 1915 Filed G. McConville REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH Jan 9, 1915 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from investigated the death of Elijah Armstrong on March 20, 1915 and that death occurred on the date stated above, at about 10 a.m. | | | |
| The CAUSE OF DEATH* was as follows: Accidental poisoning by falling from a row boat (Duration) 1 yrs. 0 mos. 0 ds. | | | |
| Contributory Secondary (Duration) 1 yrs. 0 mos. 0 ds. | | | |
| (Signed) Wm. H. Steyer 3/20, 1915 (Address) St. St. | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds. Where was disease contracted, If not at place of death? Former or usual residence. | | | |
| 19 PLACE OF BURIAL OR REMOVAL Asbury Cemetery | | DATE OF BURIAL Mar 23, 1915 | |
| 20 UNDERTAKER Fiskler & Fiskler | | ADDRESS 1738 E. Eager | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

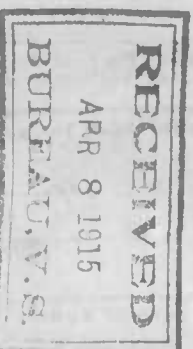
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

167

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 36Village or City Near Parkton (No. _____) St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Julius Lewis Grant Arnold

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Sept 27, 1872
(Month) (Day) (Year)

7 AGE 43 yrs 4 mos. 11 LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer) Living Business

9 BIRTHPLACE (State or country) Bresterstown, Md.

10 NAME OF FATHER John W. Arnold

11 BIRTHPLACE OF FATHER (State or country) Seamole County

12 MAIDEN NAME OF MOTHER Bailey

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence B. Arnold(Address) 2537 Francis St. Baltimore15 Filed Jan 4, 1914 T. W. Jay, Jr., M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 2, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h. _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m,

The CAUSE OF DEATH* was as follows:

Came to his death from cause unknown to the jury
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Signed) Thomas Mc Hill, M.D.
Jan 2, 1915. (Address) Parkton, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Old Mt. Cemetery, Parkton, Md. DATE OF BURIAL Jan 5, 1915

20 UNDERTAKER Ed. Lloyd Stiffen ADDRESS Parkton, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

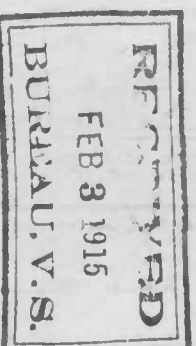
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Imitation," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 168

County BaltimoreVillage or City Bay View Asylum (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Wm. Ash.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH

Jan. 16, 1836
(Month) (Day) (Year)

7 AGE

39 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Garb. Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland.

PARENTS

10 NAME OF FATHER

Wm. Ash.

11 BIRTHPLACE OF FATHER (State or country)

Baltimore.

12 MAIDEN NAME OF MOTHER

D. Carpenter.

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Bay View

15

Filed Jan 24, 1915Wm. B. Brothers
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 24, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 16, 1915, to Jan. 24, 1915,
that I last saw him alive on Jan 23, 1915and that death occurred on the date stated above, at 8:10 17 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Pulmonale.(Duration) 1 yrs. 0 mos. 0 ds.Contributory
Secondary(Duration) 1 yrs. 0 mos. 0 ds.(Signed) J. F. Callahan, M. D.Jan 24, 1915 (Address) City He Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death 8 yrs. 0 mos. 0 ds. In the Life State Life yrs. 0 mos. 0 ds.Where was disease contracted, Widow

If not at place of death?

Former or usual residence 238 S. Calhoun St

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Olivet Jan 25, 1915

20 UNDERTAKER

ADDRESS

Wm. B. Brothers 27 Fulton

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, STRENDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Baltimore

169

(9)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

38

Village or City

Roland Park

(No.)

601 Edgerdale Road

St.:

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Florence Elizabeth Baird

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

February41915

(Month)

(Day)

(Year)

7 AGE

3

yrs.

11

mos.

13

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE

(State or country)

New York

PARENTS

10 NAME OF FATHER

Edw. J. Baird

11 BIRTHPLACE OF FATHER (State or country)

New Jersey

12 MAIDEN NAME OF MOTHER

Florence Barker

13 BIRTHPLACE OF MOTHER (State or country)

New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr Edw J Baird

(Address)

601 Edgerdale Road

15

Filed

Jan 17, 1915N. G. PorterDeputy Town

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 17

, 1915

(Month)

(Day)

(Year)

17

HEREBY CERTIFY, That I attended deceased from

Jan 16

1915

to

Jan 17

1915

that I last saw him

alive on

Jan 13Dec.

1915

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Septic Themia - Rossetti's
febrile

Contributory Secondary

Modiqueant Stomachic
causing death from moderate of non

(Signed)

Henry J. Cassidy

, M. D.

Jan 17

1915

(Address)

Roland Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn, N.Y.Jan 18, 1915

20 UNDERTAKER

ADDRESS

Stewart-Morgan Company
100 W. North Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

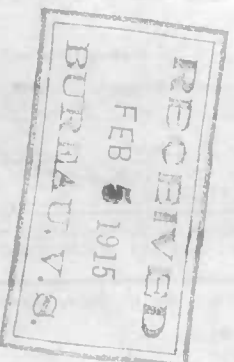
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial nephritis*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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170

1 PLACE OF DEATH
County Racine Balto (92)
Village or City Liberty Rd (No. _____) St; _____ Ward _____
2 FULL NAME Bamba Booker

STATE OF MARYLAND
CERTIFICATE OF DEATH
Registered No. 31
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|---|--|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE MARRIED WIDOWED DIVORCED (Write the word) <u>Widow</u> |
| 6 DATE OF BIRTH <u>Apr 14</u> , 18 <u>21</u> (Month) (Day) (Year) | | |
| 7 AGE <u>94</u> yrs. <u>8</u> mos. <u>24</u> ds. | | If LESS than 1 day, _____ hrs. OR _____ min. ? |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Invalid</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| 9 BIRTHPLACE (State or country) <u>Germany</u> | | |
| PARENTS | 10 NAME OF FATHER <u>Geat</u> | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> | |
| | 12 MAIDEN NAME OF MOTHER <u>ack mnt gwen</u> | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>?</u> | |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Harina Kloth
(Address) Racine Balto

15 Filed Jan 9, 1915 H. J. Shipley
REGISTRAR
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 7th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 5th, 1915 to Jan 7th, 1915 that I last saw him alive on Jan 7th, 1915 and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Pulver Pneumonia
(Duration) _____ yrs. _____ mos. 3 ds.
Contributory (Secondary) Infirmity of Age
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. C. Smith, M. D.
Jan 8th, 1915 (Address) W. - Faint Hall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Mt Oliv DATE OF BURIAL Jan 10, 1915
20 UNDERTAKER H. S. Mass Hall 3539 Fall Rd ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore.Village or City Bay View Asylum

(No.)

Registration Dist. No. 441

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

el gratz Politz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH 1896
(Month) (Day) (Year)

7 AGE 19 yrs. 0 mos. 0 ds. It LESS than 1 day, 0 hrs. 0 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Gen'l laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Russia

10 NAME OF FATHER Samuel Politz

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER Martha Maloski

13 BIRTHPLACE OF MOTHER (State or country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15 Filed Jan 30, 1915 Mrs. M. B. Miller
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 28, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1915 to Jan 28, 1915.

that I last saw him alive on Jan 28, 1915.

and that death occurred on the date stated above, at 10:50 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis.(Duration) Unknown ds.Contributory
Secondary(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) J. F. Callahan
Jan 28, 1915 (Address) City Hb Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 22 ds. In the State Unknown ds.

Where was disease contracted, Unknown

If not at place of death? Unknown

Former or usual residence 618 S. Charles St.

19 PLACE OF BURIAL OR REMOVAL St. Evangelical bur DATE OF BURIAL Feb 1st, 1915

20 UNDERTAKER Charles Miller ADDRESS 2334 Jefferson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

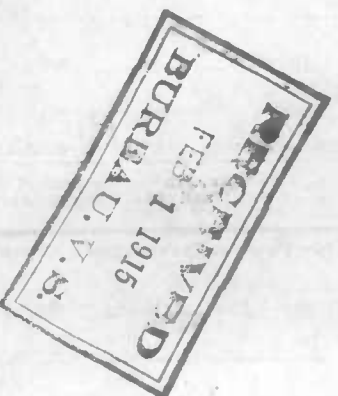
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 172
County Baltimore

Village or City Bay View Asylum (No. 28) St. Ward

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Frank Buchanilia

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Jan 5, 1862
(Month) (Day) (Year)

7 AGE 53 yrs. 5 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?
1 day, 0 hrs. 0 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Gen'l Clerk
(b) General nature of Industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

PARENTS
10 NAME OF FATHER Adam Buchanilia
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER Elizabeth Pauline
13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records
(Address) Bay View

15 Filed Jan 29, 1915 5 McKam Barr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 28, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1915 to Jan 28, 1915.

that I last saw him alive on Jan 28, 1915

and that death occurred on the date stated above, at 10:00 P.M.

The CAUSE OF DEATH* was as follows:

Phtneis Pulmonalis

(Duration) Unknown ds.

Contributory
Secondary

(Duration) Unknown yrs. 0 mos. 0 ds.

(Signed) F. J. Callahan, M. D.
Jan 28, 1915 (Address) City & Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 23 yrs. 0 mos. 0 ds. In the Unknown State Unknown ds.

Where was disease contracted, Unknown

If not at place of death? Unknown

Former or usual residence 223 Regester St.

19 PLACE OF BURIAL OR REMOVAL Sacred Heart Church DATE OF BURIAL Jan 30, 1915

20 UNDERTAKER F. S. Sanders & Son ADDRESS 1701 E. Balto St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

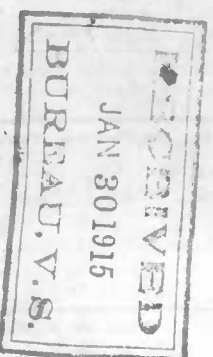
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

173

County Baltimore

Village or City Hamilton

(No. 100 Birchwood Ave)

St.; Ward

Registered No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James Henry Barnes

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH March 26, 1843
(Month) (Day) (Year)

7 AGE 71 yrs. 9 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Conductor Rail Road
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H. Barnes

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Wilkinson

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Blanche Keister

(Address) Hamilton, Balt Co Md

15 Filed Jan 19, 1915 Claude J. Jones
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 27, 1914, to January 18, 1915.

that I last saw him alive on January 18, 1915.

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Measles Poisoning
from Bright's Disease

(Duration) 3 yrs. — mos. — ds.

Contributory (Secondary) Birchosis of the Liver +

Bright's Disease (Duration) 2 yrs. — mos. — ds.

(Signed) George B. E. Gogley, M. D.

Jan 19, 1915 (Address) Hamilton, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Joe B. Cook London, Ky Jan 21, 1915

20 UNDERTAKER ADDRESS

1003 H. Balto St 1003 H. Balto St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

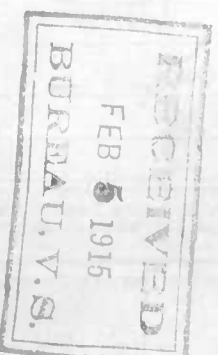
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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174
PLACE OF DEATH City Detention Hospital
for Insane.

County ltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Bay View Asylum (No. 67) St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Howard Beatty

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH _____, 1879
(Month) (Day) (Year)

7 AGE 35 yrs. 1 mos. 1 ds. OR 1 day, 1 hrs. 1 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (State or country) _____
12 MAIDEN NAME OF MOTHER _____
13 BIRTHPLACE OF MOTHER (State or country) _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wife, Mrs. Beatty,(Address) 1603 Eager Street

15 Filed Jan 4, 1915 Muram Barr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 4th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 29th, 1914 to January 4th, 1915

that I last saw him alive on January 3rd, 1915and that death occurred on the date stated above, at 3.15 A.m.

The CAUSE OF DEATH* was as follows:

General Paralysis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Philip Pearlman, M. D.
Jan 4, 1915 (Address) City Detention Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. 4 mos. 5 ds. In the State Life yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence 1603 Eager Street

19 PLACE OF BURIAL OR REMOVAL St. Olivet Cem. DATE OF BURIAL Jan 7th, 1915

20 UNDERTAKER St. M. Cook ADDRESS 502 E. North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

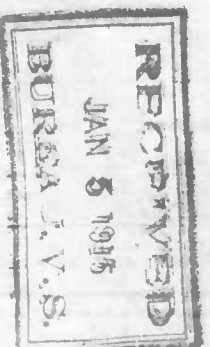
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

175

County BaltoSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 37Village or City Texas - Balto County almshouse St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Edward Beaufoy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH April 2, 1845
(Month) (Day) (Year)

7 AGE 69 yrs. 9 mos. 5 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. Barryman
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) England

PARENTS
10 NAME OF FATHER Samuel Beaufoy
11 BIRTHPLACE OF FATHER (State or country) England
12 MAIDEN NAME OF MOTHER Jane Spragg
13 BIRTHPLACE OF MOTHER (State or country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alms House Record(Address) Texas Md

15 Filed Jan 7, 1915 B. B. Benson, M.D.
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1 DATE OF DEATH Jan 7, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914 to Jan 7, 1915
that I last saw him alive on Jan 6, 1915

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Rheumatism
Chronic Heart Disease
(Duration) Several yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) B. B. Benson, M.D.

Jan 7, 1915 (Address) Cockey Mill Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. 6 mos. 11 ds. In the State 43 yrs. 2 mos. 1 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL State Burial DATE OF BURIAL Jan 7, 1915

20 UNDERTAKER Christian Miller ADDRESS Maryland Ave Jefferson H

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

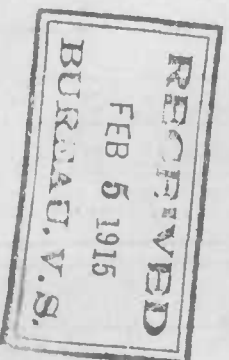
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

176

County

Baltimore

Village or City

Mt Hope

(No.)

Mt Hope Reformat

Registration Dist. No.

32

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Margaret Begley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH

Aug 4, 1874
(Month) (Day) (Year)

7 AGE

41 yrs. 6 mos. 0 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country) Delaware

PARENTS

10 NAME OF FATHER

John Begley

11 BIRTHPLACE OF FATHER

(State or country) Ireland

12 MAIDEN NAME OF MOTHER

Bridget Cassidy

13 BIRTHPLACE OF MOTHER

(State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Records of Mt Hope

(Address)

Mt Hope Md.

15

Filed

Jan. 10, 1915 Mrs. J. Queen

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 9th, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct 7, 1901, to Jan 9th, 1915.

that I last saw him alive on Jan 8th, 1915.

and that death occurred on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Delusional Mania with
Bipolar Depression

(Duration) yrs. mos. ds.

Contributory

Ex-Chronic Gastritis
Secondary

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) Frank J. Flannery, M. D.

Jan 10th, 1915 (Address) Mt Hope

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place 14 yrs. 0 mos. 0 ds. In the State 14 yrs. 0 mos. 0 ds.

Where was disease contracted? Delaware

If not at place of death? Former or usual residence Wilmington Del

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chas. Evans & Son, 1915

20 UNDERTAKER

ADDRESS

118 W. Mt. Royal

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

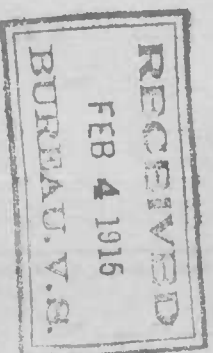
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mines*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thema," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH <u>177</u> <u>(79)</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <u>Baltimore</u> | | Registration Dist. No. <u>41</u> | |
| Village or City <u>Bay View Asylum</u> (No. <u> </u> , CITY HOSPITAL. St.; <u> </u> Ward) | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Joseph Bergman</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word) | |
| 6 DATE OF BIRTH <u> </u> , <u>1</u> <u>842</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>68</u> yrs. <u> </u> mos. <u> </u> ds. OR <u> </u> min. ? If LESS than 1 day, <u> </u> hrs. | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Coppersmith</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u> | | | |
| 9 BIRTHPLACE (State or country) <u>France</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Carl Bergman</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>France</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Theresse Gerhold</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>France</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hospital Records</u> (Address) <u>Bay View</u> | | | |
| 15 Filed <u>Jan 7</u> , 191 <u>5</u> <u>Miriam Galt</u> REGISTRAR | | | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1. | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>January</u> <u>5th</u> , 191 <u>5</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>December 9th</u> 191 <u>4</u> , to <u>Jan. 5th</u> , 191 <u>5</u> , that I last saw him alive on <u>Jan. 5th</u> , 191 <u>5</u> and that death occurred on the date stated above, <u>11.45A.</u> m. The CAUSE OF DEATH* was as follows: | | | |
| <u>Cortic Insufficiency</u> (Duration) <u>unknown</u> yrs. <u> </u> mos. <u> </u> ds. | | | |
| Contributory <u>Senility</u> Secondary <u>unknown</u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. | | | |
| (Signed) <u>M. C. Phillips</u> , M. D. <u>Jan. 5th</u> , 191 <u>5</u> . (Address) <u>CITY HOSPITAL</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u>24</u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>Bond & Eastern Ave.</u> | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Johns Hopkins Hosp</u> DATE OF BURIAL <u>Jan 7</u> , 191 <u>5</u> | | | |
| 20 UNDERTAKER <u>S. L. Hurley</u> ADDRESS <u>710 7th. Belm</u> | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

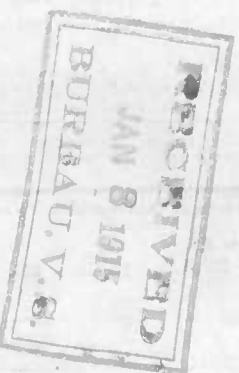
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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¹ PLACE OF DEATH Balto 178 (64)
 County Balto
 STATE OF MARYLAND
 CERTIFICATE OF DEATH
 Registration Dist. No. 44
 Village or City Bearsville (No. _____, _____ St.; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]
² FULL NAME Richard Nelson Bevan

PERSONAL AND STATISTICAL PARTICULARS

³ SEX M ⁴ COLOR OR RACE W ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED married
 (Write the word)

⁶ DATE OF BIRTH July 23, 1848
 (Month) (Day) (Year)

⁷ AGE 73 yrs. 11 mos. 20 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

⁸ OCCUPATION
 (a) Trade, profession, or particular kind of work Larner
 (b) General nature of Industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) MD

PARENTS
¹⁰ NAME OF FATHER Joshua Bevan
¹¹ BIRTHPLACE OF FATHER (State or country) MD
¹² MAIDEN NAME OF MOTHER Murphy
¹³ BIRTHPLACE OF MOTHER (State or country) MD

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mrs. Mercy Bevan
 (Address) Bearsville

¹⁵ Filed July 19, 1915 J. H. H. H.
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 44
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH July 19, 1915
 (Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from 8u July 17 1915 to 9 1915,
 that I last saw him alive on _____, 1915

and that death occurred on the date stated above, at 2:15 p. m.
 The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory Arteriosclerosis
 Secondary (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John D. H. H., M. D.
July 18, 1915 (Address) Middle River

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence _____

¹⁹ PLACE OF BURIAL OR REMOVAL Camp Chapel DATE OF BURIAL July 19, 1915
²⁰ UNDERTAKER Mr. Fisher ADDRESS Julia

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

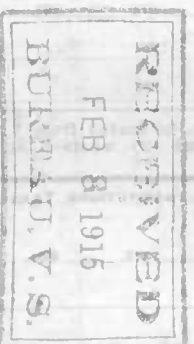
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverter wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

179

County

Baltimore

Village or City

Halethorpe

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 172

2 FULL NAME

Biden

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

unknown

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)Single

6 DATE OF BIRTH

1 9, 1915
(Month) (Day) (Year)

7 AGE

3 months

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Halethorpe, Washington Road

PARENTS

10 NAME OF FATHER

James H. Biden11 BIRTHPLACE OF FATHER
(State or country)Ind

12 MAIDEN NAME OF MOTHER

Elizabeth Kromer13 BIRTHPLACE OF MOTHER
(State or country)Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elizabeth Kromer

(Address)

Halethorpe

15

Filed

Jan 9, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 9, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

....., 191....., to , 191.....

that I last saw him alive on , 191.....

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

3 months miscarriage
(Still - Birth)

(Duration) yrs. mos. ds.

Contributory

Secondary

Leaking teeth of wisdom

(Duration) yrs. mos. ds.

(Signed)

W. H. Hall

, M. D.

19, 1915 (Address) Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

In back lotJan 9, 1915

20 UNDERTAKER

ADDRESS

James H. BidenHalethorpe

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECEIVED
FEB 2 1915
BUREAU, V. S.

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180

1 PLACE OF DEATH

County

Baltimore

Village or City

not written

(No.

Russell

St.; Ward)

Registration Dist. No.

43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William Blackburn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

col.

5 SINGLE, MARRIED, WIDDED, OR DIVORCED
(Write the word)

divorced

6 DATE OF BIRTH

unknown
(Month) (Day) (Year)

7 AGE

60 yrs. 7 mos. 1 day, 1 hrs. 1 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Lumber

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Va.

PARENTS

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER
(State or country)

Va.

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER
(State or country)

Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Parkman

(Address)

not written

15

Filed

Jan 8, 1915 F. H. Ruhl.

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 43

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 6, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
Dec 24, 1914, to Jan 6, 1915.

that I last saw him alive on Jan 5, 1915.

and that death occurred on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Intestinal hepatitis

(Duration) 4 yrs. 4 mos. 1 ds.

Contributory
Secondary

Exhaustion

(Duration) 4 yrs. 4 mos. 1 ds.

(Signed)

Rustenburg

, M. D.

Jan 6, 1915 (Address) not written

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mr. ~~Blackburn~~ Aubrey Jan 8, 1915

20 UNDERTAKER

ADDRESS

James A. Dallen 1303 Chestnut

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

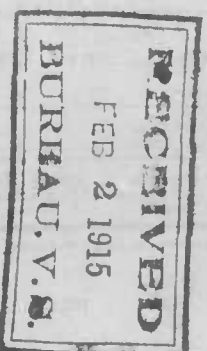
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Idianthion," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Baltimore 181
 County Baltimore (92)
 Village or City W. Washington (No. Highland Ave. St. Ward) Registered No. +83-38
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Marion Cashmere Blake

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
 (Write the word)

6 DATE OF BIRTH August 5, 1849
 (Month) (Day) (Year)

7 AGE 65 yrs. 5 mos. 13 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Baltimore Md

PARENTS

10 NAME OF FATHER John J. Holcott11 BIRTHPLACE OF FATHER (State or country) Vermont12 MAIDEN NAME OF MOTHER Annie J. Taylor13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion Blake Duff(Address) Kennock Ave. W. Washington

15 Filed Jan. 18, 1915 M. G. Porter
Deputy Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 16, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1915, to Jan. 16, 1915.

that I last saw her alive on Jan. 16, 1915and that death occurred on the date stated above, at 10:50 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 2 yrs. 2 mos. 2 ds.

Contributory (Secondary) Organic heart disease(Signed) William J. Ford, M. D.Jan. 19, 1915 (Address) W. Washington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL

Jan. 19, 1915

20 UNDERTAKER

Henry W. Means 845 N. Calvert St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

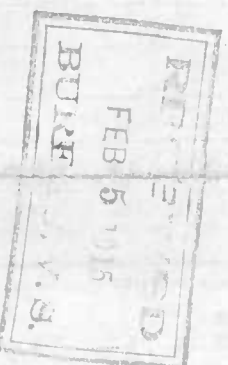
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia" "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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' PLACE OF DEATH City Detention Hospital for Insane STATE OF MARYLAND
CERTIFICATE OF DEATH

County BaltimoreBay View Asylum.Registration Dist. No. 4Village or City _____ (No. 91) St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Henrietta Bolst

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)

6 DATE OF BIRTH _____, 1850
 (Month) (Day) (Year)

7 AGE _____ If LESS than 1 day, _____ hrs.
55 yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

PARENTS
 10 NAME OF FATHER Unknown
 11 BIRTHPLACE OF FATHER (State or country) Germany
 12 MAIDEN NAME OF MOTHER Unknown
 13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Husband, Frederick Bolst
 (Address) 173 N. Duncan Street

15 Filed Jan 15, 1915 Miriam Bair
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 14th, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 27th, 1914, to January 14th, 1915.

that I last saw her alive on January 14th, 1915.

and that death occurred on the date stated above, at 5.30 P.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) _____ yrs. _____ mos. 5 ds.

Contributory Broncho Pneumonia
 Secondary

(Signed) Harry Gledsmith, M. D.
City Detention Hosp.
 1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. 6 mos. 18 ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? Unknown

Former or usual residence 173 N Duncan Street

19 PLACE OF BURIAL OR REMOVAL Mt. Carmel Cemetery DATE OF BURIAL Jan 15, 1915

20 UNDERTAKER Henry Lutz ADDRESS 10079 Bond St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

V. S. No. 1.

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

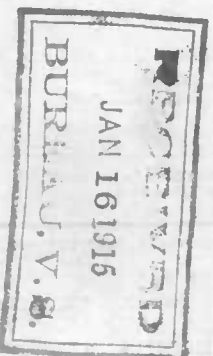
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County BaltimoreVillage or City Heathbrook Pk. No. 1017 Falls Road St.; _____ Ward)

2 FULL NAME

Wilton W. BondsSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 18538

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH April 17, 1882
(Month) (Day) (Year)

7 AGE 32 yrs. 9 mos. 2 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Motorman
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER John Bond
11 BIRTHPLACE OF FATHER (State or country) Md.
12 MAIDEN NAME OF MOTHER Annie McShultz
13 BIRTHPLACE OF MOTHER (State or country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Lilly Maud Bond
(Address) #1017 Falls Road

15 Filed Jan 21, 1915 N. G. Porter
Deputy Local REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 19, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1/7, 1915, to 1/19, 1915, that I last saw him alive on 1/19, 1915

and that death occurred on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) ____ yrs. ____ mos. 13 ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Geo. W. D. Hoff, M. D.
Jan 21, 1915 (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St. John's Presbyter. Cemetery DATE OF BURIAL Jan. 22, 1915
Christminster Rd.

20 UNDERTAKER Chenoweth & Son ADDRESS 3617 Chestnut Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

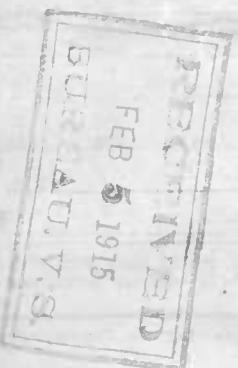
Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County BaltimoreVillage or City Bay View Asylum.(No. 81) CITY HOSPITALRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Samuel Boston

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH 1840
(Month) (Day) (Year)

7 AGE 75 yrs. 7 mos. 15 ds. It LESS than 1 day, 15 hrs. OR 15 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Henry Boston

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emaline Holland

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15 Filed Feb. 2nd, 1915 Mrs. J. M. Bass
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 31st, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 29th, 1915, to January 31, 1915.

that I last saw him alive on January 31st, 1915.

and that death occurred on the date stated above, at 10.15 P.

The CAUSE OF DEATH* was as follows:

Senility
(Duration) unknown yrs. 0 mos. 0 ds.

Contributory Asthenia Sclerosis
Secondary unknown yrs. 0 mos. 0 ds.

(Signed) W. C. Puccia, M. D.

Feb. 1st, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, unknown

If not at place of death? unknown

Former or usual residence 310 Pierce St. cor State.

19 PLACE OF BURIAL OR REMOVAL Col. of Physicians & Surgeons. DATE OF BURIAL Feb. 2nd, 1915

20 UNDERTAKER G. W. Hurley ADDRESS 1109 N. Gilmore St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

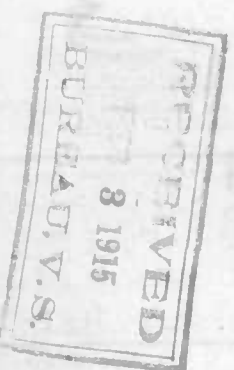
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercle of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecases*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecases* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Maras-mus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverter wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | |
|---|--|--|---|---|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 185 | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Spencetown</u> (No. <u>12</u> , W. E. St.; Ward) | | Registration Dist. No. <u>444</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |
| 2 FULL NAME <u>Brown</u> | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word) | | |
| 6 DATE OF BIRTH <u>June 28th, 1915</u> (Month) (Day) (Year) | | | | |
| 7 AGE yrs. mos. ds. If LESS than 1 day, hrs. min. ? | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | |
| 9 BIRTHPLACE (State or country) <u>Spencetown Md</u> | | | | |
| PARENTS | 10 NAME OF FATHER <u>Mr. J. Brown</u> | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Balto. Co. Md.</u> | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Elizabeth M. Single</u> | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Bu</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. S. Brown</u> (Address) <u>12 W. E. St. Spencetown Md</u> | | | | |
| 15 FILED <u>Jan 28th, 1916</u> <u>G. (H.C.) Comick M.D.</u> REGISTRAR | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| 16 DATE OF DEATH <u>June 28th, 1915</u> (Month) (Day) (Year) | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from 191....., to 191....., that I last saw h..... alive on 191..... and that death occurred on the date stated above, at m. The CAUSE OF DEATH* was as follows: <u>Stomach</u> (Duration) yrs. mos. ds. Contributory Secondary (Duration) yrs. mos. ds. (Signed) <u>F. G. Reddick</u> , M. D. <u>Jan 28th, 1915</u> (Address) <u>Spencetown</u> | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence..... | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Prospect Hill Cemetery</u> | | | | DATE OF BURIAL <u>Jan 29</u> , 1915 |
| 20 UNDERTAKER <u>W. S. Brown (Parent)</u> | | | | ADDRESS <u>Spencetown</u> |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 8 1915

BUREAU, V. S.

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1 PLACE OF DEATH

186

142

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Bay View Asylum.(No. CITY HOSPITAL)St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ellen Branning

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH

1 843
(Month) (Day) (Year)

7 AGE

72 yrs. 0 mos. 0 ds. If LESS than 1 day, 0 hrs. 0 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Ireland

PARENTS

10 NAME OF FATHER

Patrick Finnicky11 BIRTHPLACE OF FATHER
(State or country)Ireland

12 MAIDEN NAME OF MOTHER

Bridget (unknown)13 BIRTHPLACE OF MOTHER
(State or country)Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Bay View

15

Filed

Jan 29, 1915 M. Dean Bow

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 28th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from January 27th, 1915, to January 28th, 1915.that I last saw her alive on January 28th, 1915.and that death occurred on the date stated above, at 9.30 P.m.

The CAUSE OF DEATH* was as follows:

Gangrene of the Leg(Duration) yrs. 1 mos. 0 ds.Contributory
SecondaryMyocardial Insufficiency
unknown(Duration) yrs. 0 mos. 0 ds.

(Signed)

U. C. Prince

M. D.

Jan. 28th 1915 (Address)

CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 1 mos. 0 ds. In the State yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Bay View InfirmaryFormer or usual residence 3yr. - 5mo. - 21 da. in Bay View Asylum.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New CathedralFeb 12th, 1915

20 UNDERTAKER

ADDRESS

James Sigman & Son 1000 S. Paca

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

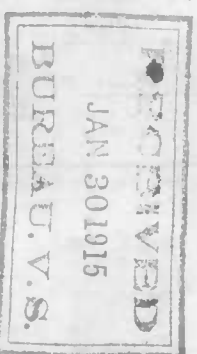
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH
County Bath Co

187

28

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 43

Village or City Prospertury (No. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Simoni Brocato

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Dec 13, 1894
(Month) (Day) (Year)

7 AGE 20 yrs. 22 mos. 22 ds. OR 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Polina Italy

PARENTS
10 NAME OF FATHER Giuseppe Brocato
11 BIRTHPLACE OF FATHER (State or country) Italy
12 MAIDEN NAME OF MOTHER Giuseppina Vaforno
13 BIRTHPLACE OF MOTHER (State or country) Polina Italy

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Vincenzo Brocato
(Address) Prospertury

15 Filed Jan 6, 1915 J. H. Clayton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 5, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 10th, 1914, to Jan 5, 1915.

that I last saw him alive on Dec 6th, 1914.

and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH was as follows:
Acute Phthisis Pulmonalis

Contributory Exhaustion (Duration) 7 yrs. _____ mos. _____ ds.
Secondary Apoplexy (Duration) 1 yr. _____ mos. _____ ds.

(Signed) W. H. H. H., M. D.
Jan 6, 1915 (Address) 607 1/2 Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St Vincent Cem DATE OF BURIAL Jan 7, 1915

20 UNDERTAKER Philip Herwig ADDRESS 2816 Orleans St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

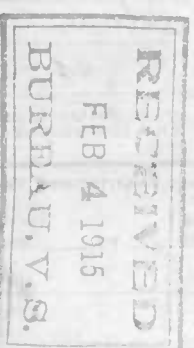
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County

Baltimore

188

(9)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No.

42

Village or City

Mt. Airy

(No.

Maine

St;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles D. Brooks

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Oct 30, 1910

(Month) (Day) (Year)

7 AGE

4 yrs. 2 mos. 3 ds. OR LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Samuel M. Brooks

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Larrie L. Kiser

13 BIRTHPLACE OF MOTHER (State or country)

West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Larrie L. Brooks

(Address)

Mt. Airy

15

Filed Jan. 4, 1915 F. H. Ruhl

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 3, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 2, 1915 to Jan 3, 1915

that I last saw him alive on Jan 3, 1915

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

same

(Duration) yrs. mos. 3 ds.

(Signed)

Geo S McKieffer

M. D.

Jan 3, 1915 (Address) Mitchell Park Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill

Jan 4, 1915

20 UNDERTAKER

ADDRESS

John J. Conner 201 Hollings

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JAN 5 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH <u>189</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <u>Baltimore</u> | | Registration Dist. No. <u>41</u> | |
| Village or City <u>Bay View Asylum.</u> | | (No. <u>31</u> CITY HOSPITAL, St.; <u>Ward</u>) | |
| 2 FULL NAME <u>Maud Brown</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>Black</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word) | |
| 6 DATE OF BIRTH <u>1887</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>28</u> yrs. <u>0</u> mos. <u>0</u> ds. OR <u>1</u> day, <u>0</u> hrs. <u>0</u> min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Domestic</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) <u>North Carolina</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Henry Forden</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>North Carolina</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Hattie Keeling</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>North Carolina</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hospital Records</u> (Address) <u>Bay View</u> | | | |
| 15 FILED <u>Jan 11</u> , 191 <u>5</u> <u>Miriam Burr</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>January 10th</u> , 191 <u>5</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Dec. 10th, 1914</u> to <u>January 10, 1915</u> , that I last saw her alive on <u>January 10th</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>2.30 P.m.</u> , The CAUSE OF DEATH* was as follows: <u>Tubercular Enteritis</u> | | | |
| Contributory <u>Fistula - in Ano</u> Secondary <u>unknown</u> (Duration) <u>unknown</u> yrs. <u>0</u> mos. <u>0</u> ds. | | | |
| (Signed) <u>W. Houston Toulson</u> , M. D. <u>Jan. 11, 1915</u> (Address) <u>CITY HOSPITAL</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u>Argyle Ave.</u> | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Johns Hopkins Hosp Jan 11</u> , 191 <u>5</u> 20 UNDERTAKER <u>G. L. Hurley</u> ADDRESS <u>1109 Y. Hill</u> | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

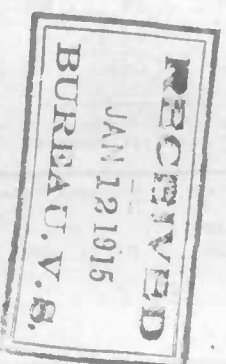
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. If or many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faithfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestual," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Baltimore 190

Village or City Madison (No. 113)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registered No. 40

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Quinn Brown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Nov 4th, 1868
(Month) (Day) (Year)

7 AGE 46 yrs. 2 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Arkansas

10 NAME OF FATHER Robert S. Crampton

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (State or country) Arkansas

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward P. Biscare

(Address) Bradshaw, Md.

15 Filed Jan 28, 1915 J. F. Gorsuch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 27th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 3rd, 1912, to Jan 26th, 1915

that I last saw her alive on Jan 26th, 1915

and that death occurred on the date stated above, at 10.20 a.m.

The CAUSE OF DEATH* was as follows

Sclerosis of Liver
and Complications

(Duration) 15 yrs. 0 mos. 0 ds.

Contributory (Secondary) General failure of vitality

(Duration) 0 yrs. 0 mos. 6 ds.

(Signed) C. H. Meyer, M. D.
1/27, 1915 (Address) Taffer Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Johns Kingville, Jan 29, 1915

20 UNDERTAKER ADDRESS

David Davidson Bradshaw

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

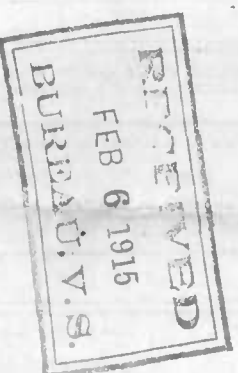
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds. Never report *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore

191

⑨

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Highlandtown (No. Sydenham Hospital St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mabel Bryan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Unknown
(Month) (Day) (Year)

7 AGE 9 yrs. — mos. — ds. OR — min. ?
It LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of Industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Baltimore, Md.

10 NAME OF FATHER Michael Bryan

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Simpson

13 BIRTHPLACE OF MOTHER (State or country) Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos. B. Cook(Address) 1003 W. Balto. St.

15 Filed Jan. 30th, 1915 J. H. Hagan, Md.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 29th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29th, 1915 to Jan. 29th, 1915,
that I last saw her alive on Jan. 29th, 1915.

and that death occurred on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:
Nasal and Tonsillar dysplasia

(Duration) Unknown yrs. mos. ds.

Contributory Profound toxemia
Secondary Unknown

(Signed) J. H. Hagan, M. D.
Jan. 30th, 1915 (Address) Sydenham Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 mos. In the State 9 yrs. mos. ds.

Where was disease contracted, UnknownIf not at place of death? UnknownFormer or usual residence 508 S. Hanover St.

19 PLACE OF BURIAL OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Jan. 30th, 1915

20 UNDERTAKER Jos. B. Cook ADDRESS 1003 W. Balto. St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

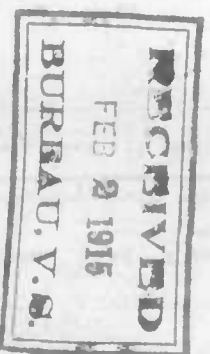
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH
County Balto

Village or City Mr Washington Falls Road (No. 151) St. Ward

2 FULL NAME Roland Bryan Jr

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH June 8, 1915
(Month) (Day) (Year)

7 AGE yrs. mos. ds. OR 1 day 23 hrs. If LESS than 1 day

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto - Md

PARENTS

10 NAME OF FATHER Roland Bryan

11 BIRTHPLACE OF FATHER (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sophia Frick

13 BIRTHPLACE OF MOTHER (State or country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roland Bryan
(Address) Mr Washington Falls Rd

15 Filed June 9, 1915 Clara Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 9, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1915 to June 9, 1915.
that I last saw him alive on June 9, 1915.

and that death occurred on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:

Primaturity (8th month)
(Duration) yrs. 13 mos. ds.

Contributory Secondary Unknown
(Duration) yrs. mos. ds.

(Signed) S. Williams, M. D.
June 9, 1915 (Address) 865 W. 36th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Laters Cemetery Balto DATE OF BURIAL June 9, 1915

20 UNDERTAKER John Burns Sons ADDRESS Towson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

193

County BaltoSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Highlandtown No. 111 S. Clinton St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Anna R. Burmeister

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)6 DATE OF BIRTH April 23, 1882
(Month) (Day) (Year)7 AGE 72 yrs. 9 mos. 1 ds. OR LESS than 1 day, ____ hrs. ____ min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work house work
(b) General nature of industry, business, or establishment in which employed (or employer) at home9 BIRTHPLACE (State or country) Germany10 NAME OF FATHER Roabe Robin11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER Not known13 BIRTHPLACE OF MOTHER (State or country) Germany14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frederick Burmeister(Address) 111 S. Clinton St.16 Filed Jan. 24, 1915 W. E. McQuarrie

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 24, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1914 to Jan. 24, 1915.that I last saw him alive on Jan. 24, 1915and that death occurred on the date stated above, at 3:00 m.

The CAUSE OF DEATH* was as follows:

Jaundice - 14y pathologic
circosis

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Branchio-gramma
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Geo. L. M. M. M., M. D.Jan. 25, 1915 (Address) 6 W. M. M.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Pauls DATE OF BURIAL Jan. 27, 191520 UNDERTAKER Sander Duns ADDRESS 1710 E. 1st St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

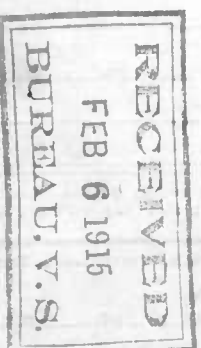
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—deceased*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County BaltimoreVillage or City Loraleys Ind.(No. 81)Registration Dist. No. 40St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Edward Codrington Carrington

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

ORDIVORCED

(Write the word)

Married

6 DATE OF BIRTH

June 6, 1847
(Month) (Day) (Year)

7 AGE

67 yrs. 7 mos. 25 ds. OR LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Va

PARENTS

10 NAME OF FATHER

Edward C. Carrington

11 BIRTHPLACE OF FATHER (State or country)

Va

12 MAIDEN NAME OF MOTHER

Mary A. Proff

13 BIRTHPLACE OF MOTHER (State or country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

40 E. Lexington Place, Wash. D. C.

15

Filed

Jan 31, 1915

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

Jan 31, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 31, 1915, to Jan 31, 1915,
that I last saw him alive on Jan 30, 1915and that death occurred on the date stated above, at 9:20 A. M.

The CAUSE OF DEATH* was as follows:

arterio sclerosis(Duration) 4 yrs. mos. ds.

Contributory (Secondary)

Not known(Duration) 4 yrs. mos. ds.

(Signed)

J. F. H. Gorman, M. D.Jan 31, 1915(Address) Fors. Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Louisa Park Ind Feb 2, 1915

20 UNDERTAKER

ADDRESS

Joseph Cook Baths Ind

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person. Irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU, V. S.

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¹ PLACE OF DEATH
County Baltimore

Village or City Bay View Asylum

(No. _____, _____ St.; _____ Ward)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 471

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME John S. Casey

PERSONAL AND STATISTICAL PARTICULARS

³ SEX male ⁴ COLOR OR RACE white ⁵ SINGLE, MARRIED, WIDDED, OR DIVORCED Single
(Write the word)

⁶ DATE OF BIRTH _____, 1863
(Month) (Day) (Year)

⁷ AGE 51 yrs. _____ mos. _____ ds. OR _____ min. ?
If LESS than 1 day, _____ hrs.

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work iron moulder.
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Balto

PARENTS
¹⁰ NAME OF FATHER unknown
¹¹ BIRTHPLACE OF FATHER (State or country) _____
¹² MAIDEN NAME OF MOTHER _____
¹³ BIRTHPLACE OF MOTHER (State or country) _____

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records
(Address) Bay View

¹⁵ Filed Jan 5, 1915 Miriam Burr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH Jan 3, 1915
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1914 to Jan. 3, 1915

that I last saw him alive on Jan. 3, 1914

and that death occurred on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Pulmonalis

(Duration) 8 yrs. 9 mos. 20 ds.

Contributory Acute enteritis & Diabetes mellitus
Secondary

(Duration) Unknown mos. _____ ds.

(Signed) J. J. Callahan, M. D.

Jan. 3, 1915 (Address) City & Hospital

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 8 yrs. 9 mos. 20 ds. In the Life State Life mos. _____ ds.

Where was disease contracted, Unknown
If not at place of death?

Former or usual residence 1813 Falls Road

¹⁹ PLACE OF BURIAL OR REMOVAL Holy Cross Cemetery DATE OF BURIAL Jan. 5, 1915

²⁰ UNDERTAKER W. J. Evans ADDRESS 118 W. 1st St. Royal

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

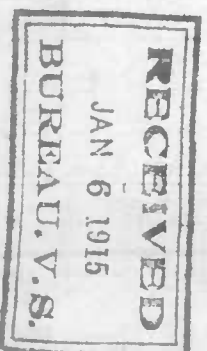
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Baltimore

196

28

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Not Yet Defined

(No.)

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Amos Chaney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

negro5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)married

6 DATE OF BIRTH

1879
(Month) (Day) (Year)

7 AGE

36 yrs. mos. ds. OR 1 LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Cement Finisher

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Ben Chaney

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Minney Haine

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Bay View

15

Filed

Jan 27, 1915Manam Bass

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 26, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec 31, 1914, to Jan 26, 1915that I last saw him alive on Jan 25, 1915and that death occurred on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis(Duration) 1 yrs. mos. ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) F. Z. Callahan, M. D.Jan 26, 1915 (Address) City & Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 26 ds. In the State Life yrs. mos. ds.Where was disease contracted, Unknown

If not at place of death?

Former or usual residence 527 Walnut Alley

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Governors Run Jan 28, 1915

20 UNDERTAKER

ADDRESS

Isiah Brown & Son 108 W. Montgomery

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

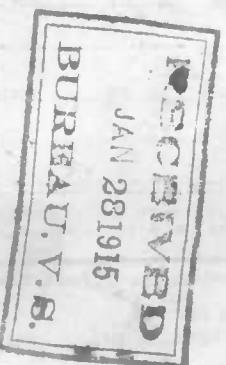
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| 1 PLACE OF DEATH | | | STATE OF MARYLAND | |
|--|--|---|---|--|
| County | | | CERTIFICATE OF DEATH | |
| 197 | | | Registration Dist. No. 41 | |
| Village or City | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| "Canton Hollow" | | | Canal Barge | |
| 2 FULL NAME | | | Infant Clark | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) | | |
| unknown | x white | Embryo | | |
| 6 DATE OF BIRTH | | | | |
| Jan. 19, 1915 | | | | |
| 7 AGE | | | | |
| If LESS than 1 day, hrs. OR min. ? | | | | |
| 8 OCCUPATION | | | | |
| (a) Trade, profession, or particular kind of work | | | | |
| (b) General nature of industry business, or establishment in which employed (or employer) | | | | |
| 9 BIRTHPLACE (State or country) | | | | |
| Maryland | | | | |
| PARENTS | 10 NAME OF FATHER | | | |
| | Charles H. Clark | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) | | | |
| New Jersey | | | | |
| 12 MAIDEN NAME OF MOTHER | | | | |
| Jane E. Myers | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) | | | | |
| New Jersey | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | |
| (Informant) Jane E. Clark | | | | |
| (Address) Canton Hollow | | | | |
| 15 | | | | |
| Filed Jan. 30, 1915 W. E. McClanahan | | | | |
| REGISTRAR | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| 16 DATE OF DEATH | | | | |
| Jan. 19, 1915 | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from | | | | |
| , 191, to , 191, , | | | | |
| that I last saw him alive on , 191, , | | | | |
| and that death occurred on the date stated above, at m. | | | | |
| The CAUSE OF DEATH was as follows: | | | | |
| Still-Born (1 month embryo) | | | | |
| (Duration) yrs. mos. ds. | | | | |
| Contributory | | | | |
| Secondary | | | | |
| (Duration) yrs. mos. ds. | | | | |
| (Signed) H. B. Titlow | | | | |
| Jan 19, 1915 (Address) 3035 O'Honnell St. | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | |
| At place of death yrs. mos. ds. In the State, yrs. mos. ds. | | | | |
| Where was disease contracted, If not at place of death? | | | | |
| Former or usual residence | | | | |
| 19 PLACE OF BURIAL OR REMOVAL | | | | |
| x Johns Hopkins Med School | | | | |
| DATE OF BURIAL | | | | |
| , 191 | | | | |
| x UNDERTAKER | | | | |
| used as Specimen | | | | |
| ADDRESS | | | | |

COPY SENT TO LOCAL REGISTRAR No. 41 DATE 1-29-15

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health
Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal septicæmia," "Prenatal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *River boat of lead—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will APPROPRIATELY CORRESPOND to the facts. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, V. S.

RECEIVED

Jan. 22 1915

BUREAU, V. S.

Sent out to be signed on this
fourth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH | | 198 | | STATE OF MARYLAND | |
|---|---------------------------------|---|--|--------------------------|--|
| County <u>Baltimore</u> | | (57) (64) | | CERTIFICATE OF DEATH | |
| Village or City <u>Overlea</u> | | (No. <u>Hennwood Ave</u> St; | | Registered No. <u>43</u> | |
| 2 FULL NAME <u>Margaret T. Codel</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u> | | | |
| 6 DATE OF BIRTH <u>Dec. 19, 1898</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>76</u> yrs. <u>1</u> mos. <u>3</u> ds. OR LESS than 1 day, ... hrs. OR ... min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Md.</u> | | | | | |
| PARENTS | | | | | |
| 10 NAME OF FATHER <u>Henry McEann</u> | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>England</u> | | | | | |
| 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>England</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Harry C. Codel</u> (Address) <u>Overlea</u> | | | | | |
| 15 Filed <u>Jan 23, 1915</u> <u>W. F. Hayton</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>Jan 22, 1915</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>July</u> , 1914, to <u>Jan 22</u> , 1915, that I last saw h. <u>En</u> alive on <u>Jan 18</u> , 1915, and that death occurred on the date stated above, at <u>5:30</u> p. m. | | | | | |
| The CAUSE OF DEATH* was as follows: <u>Arterio-sclerosis</u> (Duration) ... yrs. ... mos. ... ds. Contributory (Secondary) <u>Cerebral Hemorrhage</u> (Duration) ... yrs. <u>6</u> mos. ... ds. (Signed) <u>Albertus C. Cation</u> , M. D. <u>Jan 23, 1915</u> (Address) <u>1303 Maryland</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds. Where was disease contracted, if not at place of death? Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Cathedral Cem</u> DATE OF BURIAL <u>Jan 25, 1915</u> | | | | | |
| 20 UNDERTAKER <u>Wm. C. Black</u> ADDRESS <u>2124 Jefferson</u> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

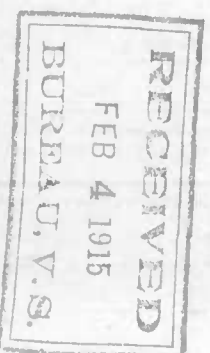
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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199

1 PLACE OF DEATH

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Highland (No. 106, S. Bouldin St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Brooke

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH June 16th, 1856
(Month) (Day) (Year)

7 AGE 58 yrs. 6 mos. 22 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Marine

9 BIRTHPLACE (State or country) England

PARENTS
10 NAME OF FATHER Not Known
11 BIRTHPLACE OF FATHER (State or country) Not Known
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (State or country) Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Brooke
(Address) 3603 Bait Ave

15 Filed Jan. 11, 1915 W. E. McClanahan
7 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1/8/15, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4th 1914 to Jan. 8/15, 1915.

that I last saw him alive on Jan. 8/15, 1915, and that death occurred on the date stated above, at 11:56 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis
(Duration) 7 yrs. 7 mos. 7 ds.

Contributory Malnutrition
Secondary (Duration) 7 yrs. 7 mos. 7 ds.

(Signed) F. H. Hermann, M. D.
1/11/15, 1915 (Address) 2919 E. Balt. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 7 yrs. 7 mos. 7 ds. In the State 7 yrs. 7 mos. 7 ds.

Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Not buried DATE OF BURIAL Jan 11/15, 1915
20 UNDERTAKER W. Sander Son ADDRESS 1710 Fleet St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

200

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty BaltimoreRegistration Dist. No. 35Village or City San Martin (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Nicholas J. Kotter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE St. Lite 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH

March 30, 1944
(Month) (Day) (Year)

7 AGE

70 yrs. 2 mos. 27 ds. OR ? min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Baltimore, Md.

PARENTS

10 NAME OF FATHER

Nicholas Kotter

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Haily

13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Kate Kotter(Address) Ireland, Md. R. 5, 1022

15

Filed Jan 29, 1945 Joseph S. Baldwin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 28, 1945
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

September 3, 1944, to January 28, 1945.that I last saw him alive on January 26, 1945.and that death occurred on the date stated above, at 2:4 m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchopneumonia
Aspiration(Duration) 2 yrs. 4 mos. 25 ds.Contributory
SecondaryAcute Leukemia(Duration) 1 yrs. 1 mos. 3 ds.(Signed) E. H. Hays, M. D.Jan 29, 1945 (Address) Parkton Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

BaltimoreJan 30, 1945

20 UNDERTAKER

ADDRESS

R. A. Trabant Fredand me

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

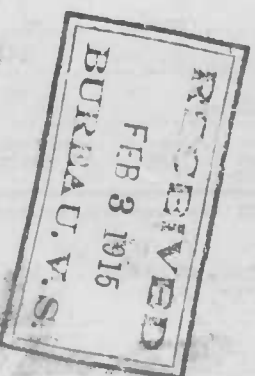
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not painfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever*. (Never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Jaundice," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc., State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 201

County BaltimoreVillage or City Baltimore (No. 28) MUNICIPAL TUBERCULOSIS HOSP. St. WardRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sadie Courney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 1886
(Month) (Day) (Year)

7 AGE 29 yrs. 0 mos. 0 ds. OR 0 min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Candy-maker
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Henry Froehner

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Josephine Biddle

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address) Bay View

15 Filed Jan 31, 1915 Miriam Burr
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 30, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1914 to Jan 30, 1915.

that I last saw her alive on Jan 30, 1915.

and that death occurred on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 1 yrs. 1 mos. 0 ds.

Contributory
Secondary

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) F. F. Callahan, M. D.
Jan 30, 1915 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 12 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, Unknown

If not at place of death? Unknown

Former or usual residence 1722 Woodrow St

19 PLACE OF BURIAL OR REMOVAL Balto. Cemetery DATE OF BURIAL Feb 2nd, 1915

20 UNDERTAKER John W. Seufel ADDRESS Layette & Truitt

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Semi," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Balto

202

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

38

Village or City

Eucowood Sanatorium, Towson, Md.

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Emma Culp

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

ORDIVORCED

(Write the word)

Separated

6 DATE OF BIRTH

October 6

(Month)

(Day)

(Year)

7 AGE

*37**3**7*

ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

Underwear Fact

9 BIRTHPLACE

(State or country)

Baltimore Md

PARENTS

10 NAME OF FATHER

W. H. Culp

11 BIRTHPLACE OF FATHER

(State or country)

New Jersey

12 MAIDEN NAME OF MOTHER

M. Rallabach

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Patience on admission

(Address)

15

Filed

*Jan 13, 1915**Claud Jones*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 13, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept 12*, 191*4*, to *Jan 13*, 191*5*that I last saw him alive on *Jan 12*, 191*5*and that death occurred on the date stated above, at *5:50 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) *2* yrs. *8* mos. — ds.Contributory
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) *Martin J. Sloan*, M. D.*1-13, 1915* (Address) *Towson*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. *3* mos. *1* ds. In the State *37* yrs. *3* mos. *7* ds.

Where was disease contracted,

If not at place of death?

Former or usual residence *2800 Block Harlem Ave.*

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*London Park**Jan 15, 1915*

20 UNDERTAKER

ADDRESS

*Just B. Cook**Balto*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

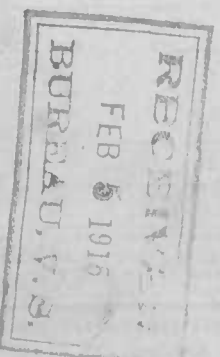
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

203

County

Baltimore

28

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 34

Village or City

Buckleyville

(No.)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Anna Curnoles

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

3 12 1844
(Month) (Day) (Year)

7 AGE

70 yrs 10 mos 15 ds
If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William C. Curnoles

(Address)

Buckleyville, Md.

15

Filed Jan 27, 1915

Cyril Elms Fowler, M.D.
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 27, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1915 to Jan 27, 1915

that I last saw him alive on Jan 27, 1915

and that death occurred on the date stated above, at 9:40 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
Interlobular
a.m.c.s.

(Duration) yrs. mos. 2 ds.

Contributory
Secondary

Heart Failure

(Duration) yrs. mos. 1 ds.

(Signed)

Edgar M. Bush

M. D.

1/27/1915 (Address) Hampstead, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mr. Groin

1-29, 1915

20 UNDERTAKER

ADDRESS

P. V. Tipton Son

Hampstead, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

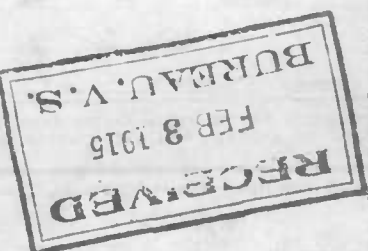
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore County

(91)

STATE OF MARYLAND
CERTIFICATE OF DEATH 41Registration Dist. No. 12Village or City Highlandtown (No. 423 S. Seventh St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lawrence Cushing

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Baby
(Write the word)6 DATE OF BIRTH November 10, 1914
(Month) (Day) (Year)7 AGE 2 yrs. 10 mos. 9 ds. It LESS than 1 day, hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work. Infant Baby
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Highlandtown10 NAME OF FATHER Joseph Cushing11 BIRTHPLACE OF FATHER (State or country) Baltimore City12 MAIDEN NAME OF MOTHER Jessie Kniff13 BIRTHPLACE OF MOTHER (State or country) Baltimore County

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Cushing
(Address) 423 S. Seventh street15 Filed Jan 20, 1915 W. E. McCarney
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 19, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1915, to Jan 19, 1915, that I last saw him alive on Jan 19, 1915.and that death occurred on the date stated above, at 7:40 a.m.
The CAUSE OF DEATH* was as follows:Broncho Pneumonia(Duration) yrs. 4 mos. ds.Contributory Toxemia
Secondary(Duration) yrs. 1 mos. ds.(Signed) W. E. McCarney, M. D.
Jan 19, 1915 (Address) 839 S. Ellwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence 19 PLACE OF BURIAL OR REMOVAL Sacred Heart Cemetery DATE OF BURIAL January 20, 191520 UNDERTAKER Winchell Lippel ADDRESS 37 S. Elm street

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PREPERAL septicæmia," "PREPERAL peritonitis," etc. State cause for violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 6 1915
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

205

County BaltoVillage or City Panton (No. 4107, 1st. Ave. St.; _____ Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Elizabeth Cyganek

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Nov 8, 1910
(Month) (Day) (Year)

7 AGE 4 yrs. 2 mos. — ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer) Chief

9 BIRTHPLACE (State or country) Baltimore Co

10 NAME OF FATHER Frank Cyganek

11 BIRTHPLACE OF FATHER (State or country) Austria

12 MAIDEN NAME OF MOTHER Elizabeth Wojek

13 BIRTHPLACE OF MOTHER (State or country) Austria

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Cyganek(Address) 4107 1st. Ave.

15 Filed Jan. 9, 1911 W. E. McLaughlin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 8, 1911
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1911, to Jan 8, 1911, that I last saw her alive on Jan 8, 1911

and that death occurred on the date stated above, at 1.50 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ yrs. _____ mos. 6 ds.Contributory
Secondary

(Signed) Col. H. H. H. H. (Duration) _____ yrs. _____ mos. _____ ds.
Jan 8, 1911 (Address) 1055 Park View, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL St. Stanislaus DATE OF BURIAL Jan 10, 1911

20 UNDERTAKER William J. Aspinwall ADDRESS 1618 Eastern

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

AW

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

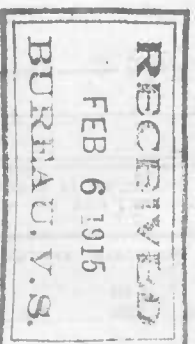
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tanution," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septichaemia," "Puerperal, peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 401 PLACE OF DEATH
County BaltimoreVillage or City Unionville (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Morris Dapprich

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)6 DATE OF BIRTH July 24th, 1840
(Month) (Day) (Year)7 AGE 74 yrs. 5 mos. 20 ds. OR LESS than 1 day, _____ hrs. OR _____ min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Farm Manager
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Germany10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. J. Janke
(Address) Glenarm R.F.D. #1 Md.15 Filed Jan 6, 1915 L.F. H. Gorman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 4th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1914 to Jan 4, 1915, that I last saw him alive on Jan. 4, 1915and that death occurred on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:Severe burns of both hands & arms
Tellon & hair - wound from M.B.
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Congestion of lungs
Secondary
(Duration) _____ yrs. _____ mos. _____ ds.(Signed) John S. Green, M. D.
Jan 5, 1915 (Address) Stittings, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Chestnut Grove Cem. Balto. Co. Md. DATE OF BURIAL Jan. 8th, 191520 UNDERTAKER Blade Bros. ADDRESS Long Green Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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RECEIVED
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BUREAU. V. S.

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1 PLACE OF DEATH

207

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Baltimore

Registration Dist. No. 42

Village or City

St. Denis

(No. _____)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Ann Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

Married

6 DATE OF BIRTH

December 26, 1880
(Month) (Day) (Year)

7 AGE

34 yrs. 1 mos. 2 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Maryland

PARENTS

10 NAME OF FATHER

George W. Crawford

11 BIRTHPLACE OF FATHER
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elizabeth Knorr

13 BIRTHPLACE OF MOTHER
(State or country)

Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George W. Crawford

(Address)

St. Denis Md

15

Filed Jan. 29, 1915 F. H. Kuhl

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 28, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191.

that I last saw him alive on , 191.

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Resolved wounds of chest—
Homicide
(Duration) yrs. mos. ds.

Contributory
Secondary

(Signed) Samuel L. Housholder, M.D.
Jan. 28, 1915 (Address) St. Denis Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grounston Park Cem. Jan 31st, 1915

20 UNDERTAKER

ADDRESS

L. Schloman & Son 26 Hanover St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

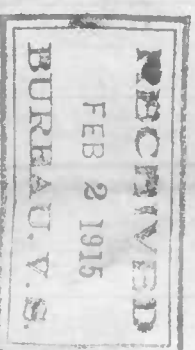
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH
County Baltimore 208 (28)
Village or City Roland Park (No. 110 Hawthorne Road St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Harry Roland Deane

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan 25, 1889 (Month) (Day) (Year)

7 AGE 26 yrs. 2 mos. 2 ds. OR 1 day, 1 hrs. 1 min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Clerk (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baets. md

10 NAME OF FATHER Dr John W. Deane

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Annie M. Keenan

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie W. Deane

(Address) 110 Hawthorne Road

15 Filed Jan. 26, 1915. W. G. Porter

Reg. Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 25, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1914, to Jan 25, 1915.

that I last saw him alive on Jan. 24, 1915.

and that death occurred on the date stated above, at 3,000 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 2 yrs. + mos. + ds.

Contributory
Secondary

(Duration) 1 yrs. + mos. + ds.

(Signed) Colburn P. Smith, M. D.
Jan 26, 1915. (Address) 6474 Colburn St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Druid Ridge DATE OF BURIAL Jan 27, 1915

20 UNDERTAKER E. W. Mitchell ADDRESS 1601 W. Fayette St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not finally employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

269

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41
 Village or City Bay View Asylum (No. City, Detention Hospital St. Ward for Insane.)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George DeGroft

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

 6 DATE OF BIRTH 1832
(Month) (Day) (Year)

 7 AGE 83 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?
If LESS than 1 day, ... hrs. ... min. ?

 8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

 9 BIRTHPLACE (State or country) Gettsburg, Pa.

 PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (State or country) "
12 MAIDEN NAME OF MOTHER "
13 BIRTHPLACE OF MOTHER (State or country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View
 15 Filed Jan 4, 1915 Thurman Baird
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH January 3rd, 1915
(Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from Jan. 2nd, 1915 to Jan. 3rd, 1915.
that I last saw him alive on Jan. 3rd, 1915.and that death occurred on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Uremia - Mitral Stenosis
a.m.c.s.
(Duration) 0 yrs. 0 mos. 0 ds.Contributory
Secondary(Duration) 0 yrs. 0 mos. 0 ds.
 (Signed) Philip Pearlstein, M. D.
Jan 3, 1915 (Address) City Detention Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

 At place of death 1 yrs. 0 mos. 0 ds. In the State 5 yrs. 0 mos. 0 ds.
Where was disease contracted, If not at place of death? ?Former or usual residence 2208 Oak St.
 19 PLACE OF BURIAL OR REMOVAL Frederick, Md. DATE OF BURIAL Jan. 7th, 1915

 20 UNDERTAKER Wm. Cook ADDRESS 502 E. North Ave.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

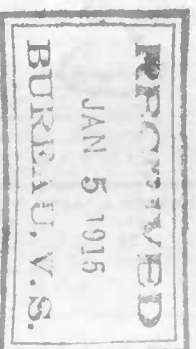
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Swollen," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

210

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highlandtown

(No. 3300 Colgate

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Clemens Deitrich

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Jan 24, 1869

(Month)

(Day)

(Year)

7 AGE

46

yrs.

mos.

ds.

If LESS than
1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Labourer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto. Md.

PARENTS

10 NAME OF
FATHER

John Deitrich

11 BIRTHPLACE
OF FATHER

(State or country)

Md.

12 MAIDEN NAME
OF MOTHER

Catherine Chhabber

13 BIRTHPLACE
OF MOTHER

(State or country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wife of Deitrich

(Address)

3300 Colgate St.

15

Filed

Jan 29, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 27, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov. 20, 1914, to Jan 27, 1915.

that I last saw him alive on Jan 26, 1915.

and that death occurred on the date stated above, at 10²⁷ m.

The CAUSE OF DEATH* was as follows:

Bright Green
Kidneys

(Duration) yrs. 3 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) E. W. Lammie, M.D.

Jan 28, 1915 (Address) 3502 Bank St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Baltimore Am.

DATE OF BURIAL

Jan 30, 1915

20 UNDERTAKER

Lily E. Ziehl

ADDRESS

4038 W. 11th St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

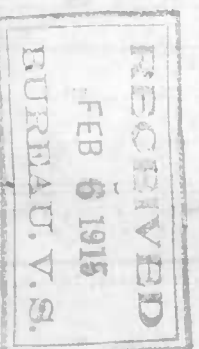
Approved by U. S. Census and American Public Health Association.¹

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

211

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 33Village or City Owings Mills (No. Rosewood State Training School St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Margaret Adelaide Delaney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH January 19, 1895
(Month) (Day) (Year)

7 AGE 20 yrs. 8 mos. 8 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm J. Delaney

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annette W. Hess

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kenneth B. Jones M.D.(Address) Owings Mills Md.

15 Filed January 26, 1915 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 26, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1914 to Jan 26, 1915
that I last saw him alive on Jan 26, 1915

and that death occurred on the date stated above, at 10:30 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 4 yrs. 4 mos. ds.Contributory Imbecility and Epilepsy
(Secondary)(Duration) 17 yrs. mos. ds.

(Signed) Kenneth B. Jones, M. D.
Jan 27, 1915 (Address) Owings Mills Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. 10 mos. 17 ds. In the State Life yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence Quintown Md.

19 PLACE OF BURIAL OR REMOVAL St. Petrus Cemetery DATE OF BURIAL Jan 29, 1915
Leon Annis Co

20 UNDERTAKER J. F. Eline ADDRESS Quintown Md.

If more blanks are needed, address State Registrar, 6 B. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

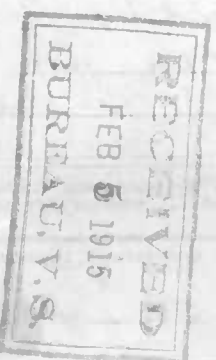
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oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scalle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septichemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore, Md.

212

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 43Village or City St. Agnes' Hospital

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mother S. Deplanch

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)Single

6 DATE OF BIRTH

May, 21, 1858
(Month) (Day) (Year)

7 AGE

57 yrs. 8 mos. 13 ds.
If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Sister of

(b) General nature of industry, business, or establishment in which employed (or employer)

Christian Education

9 BIRTHPLACE

(State or country)

Gille (France)

PARENTS

10 NAME OF FATHER

A. Deplanch

11 BIRTHPLACE OF FATHER

(State or country)

Do not know

12 MAIDEN NAME OF MOTHER

Do not know

13 BIRTHPLACE OF MOTHER

(State or country)

Do not know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sister A. Gorch

(Address)

St. Ann's College
Ashville, N. C.

15

Filed Jan. 3, 1915 Henry H. Loos

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

January 2, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec. 25, 1914, to Jan. 2, 1915that I last saw her alive on Jan. 2, 1915and that death occurred on the date stated above, at 10 pm.

The CAUSE OF DEATH* was as follows:

Uremic Intoxication

(Duration) yrs. mos. ds.

Contributory
SecondaryChronic Interstitial Nephritis

(Duration) yrs. mos. ds.

(Signed) Edwin L. Barthlett, M. D.191 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 10 ds. In the State yrs. mos. ds.Where was disease contracted, If not at place of death? St. Ann's CollegeFormer or usual residence Ashville, N. C.

19 PLACE OF BURIAL OR REMOVAL

Ashville N. Carolina Jan. 3, 1915

DATE OF BURIAL

20 UNDERTAKER

Martin Lakey & Son 606 Lafayette Ave.

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

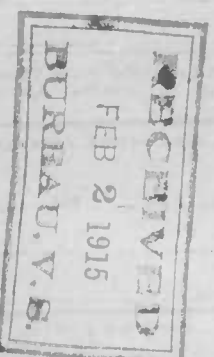
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | |
|---|---|---|--|---|--|
| 1 PLACE OF DEATH County <u>Balto</u> | | 213 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Garrison</u> | | (No. <u>64</u>) | | Registration Dist. No. <u>32</u> | |
| 2 FULL NAME <u>William Derrick</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u> | | | |
| 6 DATE OF BIRTH <u>Unknown</u> | | (Month) (Day) (Year) | | | |
| 7 AGE <u>86</u> yrs. mos. ds. | | If LESS than 1 day, hrs. OR min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Balto Co Md</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Jamey Derrick</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Balto Co Md</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | |
| (Informant) <u>Grace E. Oliver</u> | | | | | |
| (Address) <u>Onwings Mills Md</u> | | | | | |
| 15 Filed <u>1/19/1915</u> <u>Henry C. Maylor</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>Jan 18</u> , 19 <u>15</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>for some years prior to death</u> , 19 <u>15</u> , that I last saw him alive on <u>Jan 17th</u> , 19 <u>15</u> | | | | | |
| and that death occurred on the date stated above, at <u>2 a</u> m, The CAUSE OF DEATH* was as follows: | | | | | |
| <u>Paralysis</u> | | | | | |
| (Duration) <u>Unknown</u> yrs. mos. ds. | | | | | |
| Contributory <u>Apoplexy</u> | | | | | |
| Secondary (Duration) <u>Unknown</u> yrs. mos. ds. | | | | | |
| (Signed) <u>M. J. E. Maylor</u> , M. D. | | | | | |
| 1-19-1915 (Address) <u>Seleson Md</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | |
| At place of death yrs. mos. ds. In the State yrs. mos. ds. | | | | | |
| Where was disease contracted, If not at place of death? | | | | | |
| Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL | | | | | |
| <u>Piney Grove Cemetery</u> <u>Jan 20</u> , 19 <u>15</u> | | | | | |
| 20 UNDERTAKER ADDRESS | | | | | |
| <u>J. F. Eline</u> <u>Reisterstown</u> | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

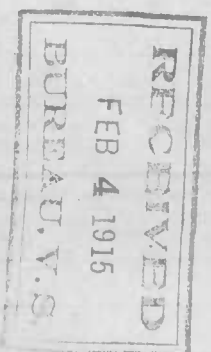
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore

214

(92)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Bay View Asylum(No. CITY HOSPITAL)St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Louis Dixon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 1 857
(Month) (Day) (Year)

7 AGE 58 yrs. 0 mos. 0 ds. If LESS than 1 day, 0 hrs. 0 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Ponter
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (State or country) II
12 MAIDEN NAME OF MOTHER II
13 BIRTHPLACE OF MOTHER (State or country) II

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records
(Address) Bay View

15 Filed Feb 2, 1915 Maryland
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 30th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 12, 1915, to January 30th, 1915.

that I last saw him alive on January 30th, 1915 and that death occurred on the date stated above, at 10.15 P.m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) 15 yrs. 0 mos. 0 ds.Contributory
Secondary(Duration) 0 yrs. 0 mos. 0 ds.(Signed) W. C. P. M. D., M. D.Feb. 1st, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 18 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, at place death
If not at place of death?

Former or usual residence 1231 Edward St.

19 PLACE OF BURIAL OR REMOVAL Seced Heart DATE OF BURIAL Feb 2nd, 1915

20 UNDERTAKER Chas. Evanson ADDRESS 118 W. Mt. Royal

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

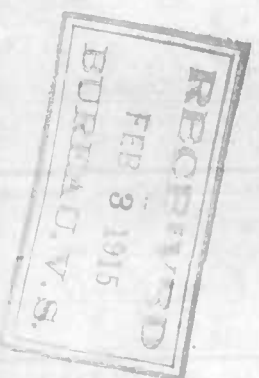
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

215

County BaltimoreVillage or City Springbank (No. 66) St.; WardSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 39

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Henry Edwards

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH Oct 2, 1840
(Month) (Day) (Year)

7 AGE 74 yrs. 3 mos. 14 ds. IF LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Cultivating soil

9 BIRTHPLACE
(State or country)Baltimore, Md.

PARENTS

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER
(State or country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lida Johnson(Address) Phoenix, Md.

15 Filed Jan. 18, 1915 Thos. H. Emory
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 16, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to Jan 16, 1915, that I last saw him alive on Jan 16, 1915

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Acute Diphtheria & Paralysis(Duration) 0 yrs. 6 mos. 10 ds.Contributory Paralysis
Secondary(Duration) 0 yrs. 0 mos. 0 ds.(Signed) Dr. J. E. Pearson, M. D.Jan 16, 1915 (Address) Cockeysville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt. Zion Cemetery Jan 19, 1915

20 UNDERTAKER ADDRESS

W. I. Chalmers Phoenix

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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RECEIVED

FEB 4 1915

BUREAU, V. S.

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¹ PLACE OF DEATH 216
County Baltimore,

Village or City Bay View Asylum (No. 28) St. Ward

Registration Dist. No. 1

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Nannie Edwards

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Female ⁴ COLOR OR RACE Black ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

⁶ DATE OF BIRTH 1884
(Month) (Day) (Year)

⁷ AGE 30 yrs. mos. ds. OR 1 day, hrs. min. ?
If LESS than 1 day, hrs. min. ?

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Maryland

¹⁰ NAME OF FATHER Jacob Edwards

¹¹ BIRTHPLACE OF FATHER (State or country) Maryland

¹² MAIDEN NAME OF MOTHER Emma Ross

¹³ BIRTHPLACE OF MOTHER (State or country) Maryland

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address) Bay View

¹⁵ Filed Jan 6, 1915 Mrs Sam Bass
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH Jan. 5, 1915
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1914, to Jan. 5, 1915.

that I last saw her alive on Jan. 5, 1915.

and that death occurred on the date stated above, at 2:10 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Pulmonalis

(Duration) Unknown ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) F. F. Callahan, M. D.

Jan 5, 1914. (Address) City St Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 1 mos. 12 ds. In the State Life mos. ds.

Where was disease contracted, Unknown

It not at place of death? Unknown

Former or usual residence 130 Calver St

¹⁹ PLACE OF BURIAL OR REMOVAL Laurel Cemetery DATE OF BURIAL Jan 8, 1915

²⁰ UNDERTAKER John W. Henderson ADDRESS 317 N. Calver

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congitial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

217

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 42Village or City St. Agnes Hospital

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Rev. Daniel H. Ellard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

April 21, 1871
(Month) (Day) (Year)

7 AGE

43 yrs. 8 mos. 23 ds. OR LESS than
1 day, ____ hrs. ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Ireland

PARENTS

10 NAME OF FATHER

D. H. Ellard11 BIRTHPLACE OF FATHER
(State or country)Ireland

12 MAIDEN NAME OF MOTHER

Mary13 BIRTHPLACE OF MOTHER
(State or country)Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister Marciana(Address) St. Agnes Hospital

15

Filed Jan 15, 1915 H. H. Loos

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 14, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept. 24, 1914, to Jan 14, 1915that I last saw him alive on Jan. 14, 1915and that death occurred on the date stated above, at 3:10 a.m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer
Operations(Duration) 5 yrs. 0 mos. 0 ds.Contributory
SecondaryEmbolism - Cerebral abscess(Duration) 0 yrs. 0 mos. 0 ds.(Signed) Henry H. Loos, M. D.Jan 14, 1915 (Address) St. Agnes Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. 2 mos. 2 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 514 Main St. Nashville, Tenn.

19 PLACE OF BURIAL OR REMOVAL

Nashville, Tenn.

DATE OF BURIAL

Removed Jan 15, 1915

20 UNDERTAKER

C. F. Evans & Sons

ADDRESS

118 W. Mt. Royal Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

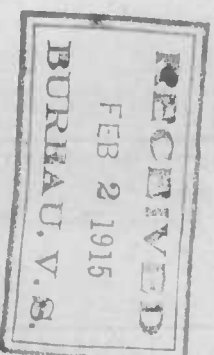
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

218

County

(Baltimore), Md.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

42

Village or City

St. Agnes' Hospital

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mr. John Ellis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

July, (General Law) 1880
(Month) (Day) (Year)

7 AGE

35 yrs. 6 mos. ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Harness-maker

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Ireland

PARENTS

10 NAME OF FATHER

John Ellis

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Keaneally

13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Ella Ellis

(Address) 137 S. Central Ave.

15

Filed

Jan 6, 1915 Henry H. Loos

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 6, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 4, 1915, to Jan. 6, 1915.

that I last saw him alive on Jan. 6, 1915.

and that death occurred on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ? yrs. mos. ds.

Contributory
Secondary

Extensive leg ulcers & infections

(Duration) ? yrs. mos. ds.

(Signed) Walter W. Doherty, M. D.

Jan 6, 1915 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence 137 S. Central Ave.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross Cem. Jan 8, 1915

20 UNDERTAKER

ADDRESS

Chas. P. Evans & Son 118 Wm. & Royal Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

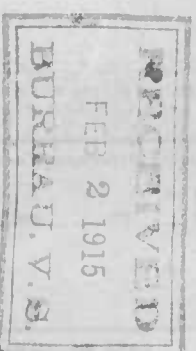
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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¹ PLACE OF DEATH
County Baltimore

219

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Ellicott (No., St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Joseph A Ellis

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Male ⁴ COLOR OR RACE White ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

⁶ DATE OF BIRTH Sept 24, 1860
(Month) (Day) (Year)

⁷ AGE 54 yrs. 4 mos. 7 ds. OR 1 day, hrs. If LESS than 1 day, hrs.

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work Clerical
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Pa

PARENTS
¹⁰ NAME OF FATHER Conrad Ellis
¹¹ BIRTHPLACE OF FATHER (State or country) Germany
¹² MAIDEN NAME OF MOTHER Maria Wolf
¹³ BIRTHPLACE OF MOTHER (State or country) Germany

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gertrude Ellis
(Address) Ellicott City

¹⁵ Filed Feb 1, 1915 Marshall B. Wolf
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH Jan 31, 1915
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1914 to Jan 31, 1915.

that I last saw him alive on Jan 30, 1915.

and that death occurred on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis & myocarditis
(Duration) yrs. mos. ds.

Contributory Uræmia
Secondary (Duration) yrs. mos. ds.

(Signed) Wm. H. Garrison, M. D.
Jan 31, 1915 (Address) Ellicott City, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL New bathedale cemetery DATE OF BURIAL Feb 2, 1915

²⁰ UNDERTAKER Easton Sons ADDRESS Ellicott City

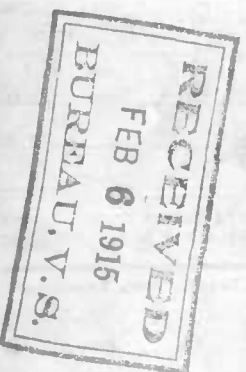
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium," "Convulsant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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STATE OF MARYLAND CERTIFICATE OF DEATH

1 PLACE OF DEATH

220

County

Baltimore

Registered No.

32

Village or City

Roslyn

(No.

St;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ruth E. Enos

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

8 20 1915
(Month) (Day) (Year)

7 AGE

1 yrs. 4 mos. 14 ds. OR 1 day. hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Bald. Co.

10 NAME OF FATHER

Chas. P. Enos

11 BIRTHPLACE OF FATHER (State or country)

Howard Co.

12 MAIDEN NAME OF MOTHER

Jennie E. Orem

13 BIRTHPLACE OF MOTHER (State or country)

Howard Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. P. Enos

(Address)

Roslyn

15

Filed Jan 17th 1915 Harry C. Naylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 3 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec 20 1914 to Jan 3 1915

that I last saw her alive on Jan 23 1915

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bacterial Pneumonia

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. E. Martin

M. D.

Jan 14 1915 (Address) Roslyn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

North Cemetery

DATE OF BURIAL

Jan 17 1915

20 UNDERTAKER

Ch. H. Kraft

ADDRESS

Pikesville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not reluctantly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 4 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Balto. 221

County Balto.

Village or City Sunnybrook (No. 40)

2 FULL NAME Elizabeth Emma Ensor

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 39

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Dec 9, 1843
(Month) (Day) (Year)

7 AGE 71 yrs. 29 ds. 7 mos. 1 day, 1 hrs. 1 min. ?
If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Md

PARENTS

10 NAME OF FATHER

George Chilcoat

11 BIRTHPLACE OF FATHER (State or country)

Md

12 MAIDEN NAME OF MOTHER

Sarah Ann Benson

13 BIRTHPLACE OF MOTHER (State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John E. Ensor

(Address) Sunnybrook Md

15

Filed Jan. 8, 1915 Thos. H. Emory
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 7, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1914, to Jan 7, 1915.

that I last saw him alive on Jan 7, 1915.

and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) 5 mos. 5 ds.

Contributory (Secondary)

(Duration) 5 yrs. 5 mos. 5 ds.

(Signed) Wilmer C. Ensor, M. D.

Jan 8, 1915 (Address) Cockeysville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 7 yrs. 5 mos. 5 ds. to the State 7 yrs. 5 mos. 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Bosley M. E. Cemetery

DATE OF BURIAL

Jan 10, 1915

20 UNDERTAKER

St. C. Brooks

ADDRESS

Sparks. Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

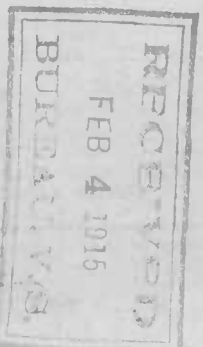
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 222 40
 County Baltimore
 Village or City Highlandtown (No. 804 S. Third St. St.; Ward) Registration Dist. No. 41
 2 FULL NAME Cettillia Eyring
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)

6 DATE OF BIRTH Dec. 13th, 1864
 (Month) (Day) (Year)

7 AGE 50 yrs. 1 mos. 1 ds. OR 1 day, 1 hrs. 1 min. ?
 II LESS than

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Housework
 (b) General nature of industry, business, or establishment in which employed (or employer) At Home

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Maximilian Herbst

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Erhard Eyring
 (Address) 804 S. Third St.

15 Filed Jan. 16, 1915 W. E. McLaughlin
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 14th, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1914, to Jan. 14, 1915,
 that I last saw her alive on Jan. 14, 1915,

and that death occurred on the date stated above, at 2:45 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Contributory Inanition
 Secondary
 (Duration) 1 yrs. 0 mos. 0 ds.

(Signed) Joseph Hamilton, M. D.
Jan. 17, 1915 (Address) 2320 Clinton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Holy Redeemer Am. DATE OF BURIAL Jan 18, 1915

20 UNDERTAKER Lilly and Zuber ADDRESS 403 S. Wagon

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

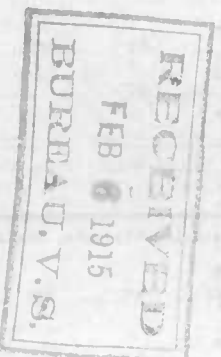
Approved by U. S. Census and American Public Health Association.¹

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Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH CITY DETENTION HOSPITAL
FOR INSANE.

STATE OF MARYLAND
CERTIFICATE OF DEATH

County Baltimore

Registration Dist. No. 41

Village or City Bay View Asylum.

(No. 81)

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Michael Fitzpatrick,

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 1840
(Month) (Day) (Year)

7 AGE 75 yrs. 7 mos. 5 ds. OR 1 day, 1 hrs. 1 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ireland

PARENTS
10 NAME OF FATHER ?
11 BIRTHPLACE OF FATHER (State or country) ?
12 MAIDEN NAME OF MOTHER ?
13 BIRTHPLACE OF MOTHER (State or country) ?

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Little Sisters of the Poor
(Address)

15 Filed Jan 21, 1915 Marian Bau
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 20th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from October 2, 1914, to January 20, 1915.

that I last saw him alive on January 20th, 1915

and that death occurred on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ? yrs. ? mos. ? ds.

Contributory Arterio Sclerosis
Secondary

(Duration) ? yrs. ? mos. ? ds.

(Signed) Philip Pearlstein, M. D.
Jan 21, 1915 (Address) City Detention Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 3 mos. 18 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence Little Sisters of the Poor

19 PLACE OF BURIAL OR REMOVAL New Cathedral DATE OF BURIAL Jan 22, 1915

20 UNDERTAKER H. C. Warfield ADDRESS 914 Hammond Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

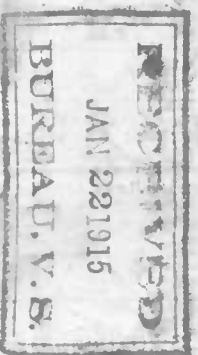
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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| | | | | | |
|---|--|--|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 224 (92) | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Bay View Asylum</u> | | (No. _____) | | Registration Dist. No. <u>41</u> | |
| 2 FULL NAME <u>James Flynn</u> | | CITY HOSPITAL | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word) | | | |
| 6 DATE OF BIRTH <u>1.854</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>59</u> yrs. <u>0</u> mos. <u>0</u> ds. <u>0</u> hrs. <u>0</u> min. ? If LESS than 1 day, hrs. OR min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Ireland</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Dunnann Flynn</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Ellen Lynn</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Ireland</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hospital Records</u> (Address) <u>Bay View</u> | | | | | |
| 15 Filed <u>Jan 4th, 1915</u> <u>Miriam Baer</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>January 4th, 1915</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Dec. 30th, 1914</u> to <u>Jan. 4th, 1915</u> that I last saw him alive on <u>Jan. 4th, 1915</u> and that death occurred on the date stated above, at <u>12.15 A.M.</u> The CAUSE OF DEATH* was as follows: | | | | | |
| <u>Lobar Pneumonia</u> (Duration) yrs. <u>6</u> mos. <u>0</u> ds. | | | | | |
| Contributory <u>Arterio sclerosis</u> Secondary <u>unknown</u> (Duration) yrs. <u>0</u> mos. <u>0</u> ds. | | | | | |
| (Signed) <u>H. C. Prince</u> , M.D. <u>Jan. 4th, 1915</u> (Address) <u>Bay View Hospital</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. <u>0</u> mos. <u>5</u> ds. In the State yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, If not at place of death? <u>unknown</u> Former or usual residence <u>Unknown</u> | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>St. Patrick's Ceme.</u> | | | | DATE OF BURIAL <u>Jan. 5th, 1915</u> | |
| 20 UNDERTAKER <u>John Moran</u> | | | | ADDRESS <u>Bank & Ann St</u> | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

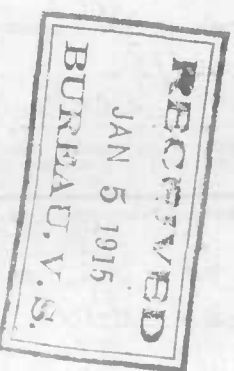
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Baltimore

Village or City Highlandtown (No. 3208 Fleet St. St.; _____ Ward)

2 FULL NAME

George FoerbachSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Feb. 26th, 1871
(Month) (Day) (Year)

7 AGE 43 yrs. 10 mos. 27 ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany.

10 NAME OF FATHER George Foerbach

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Katharine Neubauer

13 BIRTHPLACE OF MOTHER (State or country) Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret Foerbach

(Address) 3208 Fleet St.

15 Filed Jan. 26, 1915 W. E. McQuahan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 23rd, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4th, 1915, to Jan. 23rd, 1915.

that I last saw him alive on Jan. 22nd, 1915.

and that death occurred on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(Duration) _____ yrs. _____ mos. 20 ds.

Contributory Corbosis Liver

(Duration) 2 yrs. _____ mos. _____ ds.

(Signed) C. V. Atkey, M. D.
Jan. 24th, 1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Sacred Heart Am. DATE OF BURIAL Jan. 27, 1915

20 UNDERTAKER Filly & Filler ADDRESS 403 S. W. Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, STUPIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 6 1915
BUREAU U. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

226

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. _____

Village or City

Fullerton

(No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant of Elvira Foster

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Jan 29, 1915
(Month) (Day) (Year)

7 AGE

It LESS than
1 day.....hrs.
.....yrs.....mos.....ds. OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

Lawrence Smith

11 BIRTHPLACE OF FATHER

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Elvira Foster

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elvira Foster

(Address)

Fullerton

15

Filed

Jan 31, 1915 W. H. Clay, Jr.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 29, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 191....., to....., 191.....

that I last saw h..... alive on....., 191.....

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Still Born

Contributory
Secondary

(Duration).....yrs.....mos.....ds.

(Signed) W. H. Clay, Jr.

Jan 31, 1915 (Address) Overland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Family Lot

Feb 1, 1915

20 UNDERTAKER

ADDRESS

Geo. Conway

Fullerton

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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RECEIVED

FEB 4 1915

BUREAU U. S. G.

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227

1 PLACE OF DEATH
County Baltimore

Village or City Highlandtown No. 3724 Mt Pleasant St.; Ward 5

2 FULL NAME None

Registered No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

| PERSONAL AND STATISTICAL PARTICULARS | | |
|---|---|---|
| 3 SEX <u>male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> |
| 6 DATE OF BIRTH <u>January 20</u> , 1915 (Month) (Day) (Year) | | |
| 7 AGE _____ yrs. _____ mos. _____ ds. | | If LESS than 1 day, _____ hrs. OR 0 min.? |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u> | | |
| 9 BIRTHPLACE (State or country) <u>Baltimore</u> | | |
| PARENTS | 10 NAME OF FATHER <u>Charles R. Moore</u> | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore</u> | |
| | 12 MAIDEN NAME OF MOTHER <u>Julia A. Miller</u> | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore</u> | |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles R. Moore
(Address) 3724 Foster ave

15 Filed Jan 21, 1916 W. E. McLaughlin
REGISTRAR

| MEDICAL CERTIFICATE OF DEATH | |
|---|--|
| 16 DATE OF DEATH <u>January 20</u> , 191 <u>5</u> (Month) (Day) (Year) | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>January 20</u> , 191 <u>5</u> , to <u>January 20</u> , 191 <u>5</u> , that I last saw him <u>dead</u> <u>January 20</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>2:30 a.m.</u> , The CAUSE OF DEATH* was as follows: <u>Still Born</u> | |
| Contributory (Secondary) <u>Still Born</u> | |
| (Signed) <u>Dr. Schneider</u> , M. D. <u>January 20</u> , 191 <u>5</u> (Address) <u>3307 B. B. B.</u> | |

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, if not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Johns Hopkins Hosp DATE OF BURIAL Jan 20, 1915
20 UNDERTAKER W. E. McLaughlin ADDRESS Johns Hopkins

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

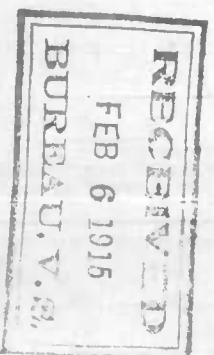
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| 1 PLACE OF DEATH | | 228 | | STATE OF MARYLAND | |
|---|--|---|--|---|--|
| County | | (S) | | CERTIFICATE OF DEATH | |
| Village or City | | Highlandtown (No. 4717 Eastern Ave) | | Registration Dist. No. 41 | |
| 2 FULL NAME | | Child of Geo. W. + Catherine Foy | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX Female | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single | | | |
| 6 DATE OF BIRTH Jan 6 th , 1915 | | 7 AGE If LESS than 1 day, _____ hrs. _____ yrs. _____ mos. _____ ds. OR _____ min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None | | | | | |
| 9 BIRTHPLACE (State or country) Md. | | | | | |
| PARENTS | 10 NAME OF FATHER Geo W. Foy | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) Md | | | | |
| | 12 MAIDEN NAME OF MOTHER Catherine Heir | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) Md | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Catherine Foy (Address) 4717 Eastern Ave | | | | | |
| 15 FILED Jan 6, 1915 W. E. W. Cavalcanti REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH Jan 9 th , 1915 (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred on the date stated above, at 12 P. m. The CAUSE OF DEATH was as follows: Stillborn | | | | | |
| Contributory Secondary (Duration) _____ mos. _____ ds. (Signed) J. S. [Signature] M. D. Jan 9 th , 1915 (Address) 3353 E. Falls | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL Trinity Cem | | | | DATE OF BURIAL Jan 7, 1915 | |
| UNDERTAKER Philip Herwig | | | | ADDRESS 2016 Orleans St | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

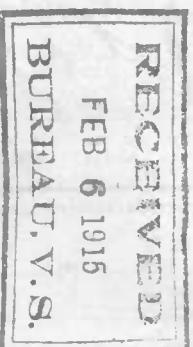
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Freeze statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not painfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



STATE OF MARYLAND
CERTIFICATE OF DEATH1 PLACE OF DEATH
County BaltimoreRegistered No. 41Village or City Highlandtown (No. 506) First St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant of Conrad and Dora Gail

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Premature6 DATE OF BIRTH 1 19, 1915
(Month) (Day) (Year)7 AGE Premature If LESS than 1 day, hrs. yrs. mos. ds. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Highlandtown Md.10 NAME OF FATHER Conrad Gail11 BIRTHPLACE OF FATHER (State or country) Balto, Md.12 MAIDEN NAME OF MOTHER Dora Wegmann13 BIRTHPLACE OF MOTHER (State or country) Highlandtown, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Conrad Gail
(Address) 506 J. First Ave.15 Filed Jan. 19, 1915 W. E. McLaughlin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 19, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from 1-19-, 1915, to 1-19-, 1915,
that I last saw her dead 1-19-, 1915,
and that death occurred on the date stated above, at home m.
The CAUSE OF DEATH* was as follows: day before birthPremature Incerated Fetus
Specific (?)

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.(Signed) Allen E. Bechtel, M.D.
1-19-, 1915 (Address) 3139 E. Balto. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oak Lawn DATE OF BURIAL Jan 20, 191520 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> (No. <u>230</u>) Village or City <u>St. Helena</u> (No. _____, St.; _____ Ward) | | STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>44</u> | |
| 2 FULL NAME <u>(still born infant) (2 1/2 months)</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] <u>Gambrell</u> | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>not determined</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word) | |
| 6 DATE OF BIRTH <u>Jan. 21st</u> , 1915 (Month) (Day) (Year) | | | |
| 7 AGE _____ yrs. _____ mos. _____ ds. | | If LESS than 1 day, _____ hrs. <u>X</u> min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u> | | | |
| 9 BIRTHPLACE (State or country) <u>St Helena Balto Co.</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Wm Gambrell</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore Md</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Mary E. Kelly</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore Md.</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr Mary E Gambrell</u> (Address) <u>St Helena</u> | | | |
| 15 Filed <u>Jan 23^d</u> , 1915 <u>G. Mc Cormick m</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>Jan. 21st</u> , 1915 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>still born. 2 1/2 months</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>not known</u> Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>G. Mc Cormick m</u> , M. D. <u>Jan 23^d</u> , 1915 (Address) <u>Spomonsdors</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____ | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Sent to Anatomical Dept</u> | | DATE OF BURIAL _____, 191____ | |
| 20 UNDERTAKER <u>Johns Hopkins Med. School</u> | | ADDRESS _____ | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

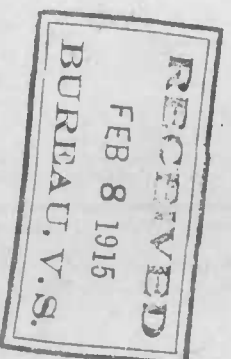
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **231**
 County Baltimore
 Village or City Sparks (No. 5) St. Ward
 2 FULL NAME Un Named (Still born) Gardner
 Registration Dist. No. 37
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
 6 DATE OF BIRTH Jan 24, 1915 (Month) (Day) (Year)
 7 AGE yrs. mos. ds. OR min. ?
 8 OCCUPATION
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 9 BIRTHPLACE (State or country) Balt Co Md

PARENTS

10 NAME OF FATHER Illegitimate
 11 BIRTHPLACE OF FATHER (State or country)
 12 MAIDEN NAME OF MOTHER Florance Virginia Gardner
 13 BIRTHPLACE OF MOTHER (State or country) Quaker Bottom Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Gardner Grandparent
 (Address) Sparks Md

15 Jan 20, 1915 J. Drach M.D.
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 37

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 25, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1915, to Jan 24, 1915, mother & Still born
 that I last saw him alive on Jan 24, 1915

and that death occurred on the date stated above, at Jan 24 m.

The CAUSE OF DEATH* was as follows:

Delay in birth due to false position & abnormal condition of cord &c
 (Duration) yrs. mos. ds.

Contributory Forced Delivery
 Secondary

(Signed) J. Drach, M. D.
Jan 25, 1915 (Address) Cockeysville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL Quaker Bottom or DATE OF BURIAL Jan 25, 1915

20 St. Stephens M. E. Church ADDRESS John Gardner Grandparent Sparks Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

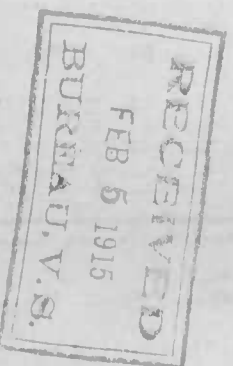
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cause" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County BaltimoreVillage or City Crowden Villa (No. 79)
Swepher Spring Road2 FULL NAME Rachel GarrettSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 42

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH March (Month) not known (Day) 1857 (Year)7 AGE 58 yrs. 0 mos. 0 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work house work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Boston Baker
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER not known
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel T. Garrett(Address) Elk Ridge Md15 Filed Jan. 27, 1915 J. P. Ruhl

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 23^d, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1914, to Jan 23, 1915, that I last saw h. er alive on Jan 18, 1915and that death occurred on the date stated above, at 11.05.0 m.

The CAUSE OF DEATH* was as follows:

Heart disease

(Duration) 2 yrs. 0 mos. 0 ds.
Contributory Heart disease
Secondary

(Duration) 2 yrs. 0 mos. 0 ds.
(Signed) Arthur Williams, M. D.
Jan 24, 1915. (Address) Elk Ridge Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Epworth Chapel Cms DATE OF BURIAL 1/27, 191520 UNDERTAKER Sam L. J. Hensley ADDRESS 548 W. Biddle

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

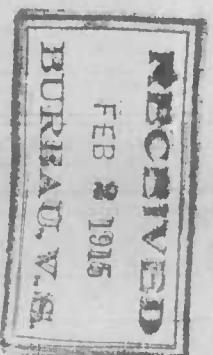
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH | | | 233 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|--|--|---|---|-------------------------------------|---|--|
| County <u>Baltimore</u> | | | (120) | | Registration Dist. No. <u>41</u> | |
| Village or City <u>Highlandtown</u> (No. <u>310 S. Clinton</u> St.; _____ Ward) | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | |
| 2 FULL NAME <u>Thomas A. Gemmill</u> | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married.</u> (Write the wife's name) | | | | |
| 6 DATE OF BIRTH _____ (Month) (Day) (Year) <u>1876</u> | | | | | | |
| 7 AGE <u>38</u> yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ? | | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Road Boss</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>U. P. E. R. R. Co.</u> | | | | | | |
| 9 BIRTHPLACE (State or country) <u>Pennsylvania</u> | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>William E. Gemmill</u> | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Pennsylvania</u> | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Elizabeth G. Campbell</u> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Pennsylvania</u> | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Lillian Gemmill</u> (Address) <u>310 S. Clinton St.</u> | | | | | | |
| 15 Filed <u>Jan. 19, 1915</u> <u>W. E. McLaughlin</u> REGISTRAR | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | |
| 16 DATE OF DEATH <u>Jan. 17, 1915</u> (Month) (Day) (Year) | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>12-21-</u> , 191 <u>4</u> , to <u>1-17-</u> , 191 <u>5</u> , that I last saw him alive on <u>1-16-</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>1.10 P. m.</u> The CAUSE OF DEATH* was as follows: <u>Chronic Interstitial</u> <u>nephritis</u> (Duration) <u>?</u> yrs. <u>?</u> mos. <u>?</u> ds. Contributory <u>Uraemia</u> Secondary (Duration) _____ yrs. _____ mos. <u>1</u> P. ds. (Signed) <u>Blukensbach P. R.</u> , M. D. <u>1-19-, 1915.</u> (Address) <u>University Hosp.</u> | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____ | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Coh Laure Am.</u> | | | | DATE OF BURIAL <u>Jan. 20, 1915</u> | | |
| 20 UNDERTAKER <u>Fitz & Zieher</u> | | | | ADDRESS <u>4038 Wofford</u> | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Cars should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 6 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | |
|--|---|---|--|---|--|
| 1 PLACE OF DEATH 234 | | <div style="border: 1px solid black; border-radius: 50%; width: 60px; height: 60px; display: flex; align-items: center; justify-content: center; margin: 0 auto;"> 105 </div> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <u>Baltimore</u> | | | | Registration Dist. No. <u>41</u> | |
| Village or City <u>Bay View Asylum.</u> | | (No. <u>Bay View Asylum</u>) | | St.; <u>Ward</u> | |
| 2 FULL NAME <u>Fredericka Gennert</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word) | | | |
| 6 DATE OF BIRTH <u>1.8.39</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>76</u> yrs. <u>7</u> mos. <u>1</u> ds. <u>1</u> hr. <u>35</u> min. <u>35</u> sec. If LESS than 1 day, hrs. ? OR min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Germany</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Unknown</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>"</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>"</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>"</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hospital Records</u> (Address) <u>Bay View</u> | | | | | |
| 15 Filed <u>Feb. 2nd 1915</u> <u>Mrs. J. B. B.</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>January 30th, 1915</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>August 28th, 1912</u> to <u>January 30th, 1915</u> , that I last saw h. <u>er</u> alive on <u>January 30th, 1915</u> , and that death occurred on the date stated above, at <u>12.35 P.</u> The CAUSE OF DEATH* was as follows: <u>Senility</u> <u>Unknown</u> (Duration) yrs. mos. ds. <u>Contributory Ulcerative Colitis</u> Secondary (Duration) yrs. mos. ds. <u>14</u> (Signed) <u>U. C. Prince</u> , M. D. <u>Feb. 1st, 1915</u> (Address) <u>CITY HOSPITAL</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>2</u> yrs. <u>5</u> mos. <u>2</u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>Bayview Asylum</u> | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>College of Physicians & Surgeons.</u> DATE OF BURIAL <u>Feb. 2nd, 1915</u> | | | | | |
| 20 UNDERTAKER <u>G. W. Hurley</u> ADDRESS <u>1109 N. Gilmore St.</u> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

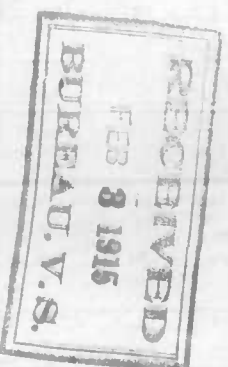
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not fairly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 235
 County Baltimore (81)
 Village or City Arlington (No. 4758 Primlico Rd) St.; German Ward)
 2 FULL NAME Elizabeth Anna German
 Registration Dist. No. 32
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow
 (Write the word)
 6 DATE OF BIRTH Jul 20, 1894
 (Month) (Day) (Year)
 7 AGE 70 yrs. 6 mos. 11 ds. If LESS than 1 day, hrs. OR min. ?
 8 OCCUPATION
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md.
 PARENTS
 10 NAME OF FATHER James R. German
 11 BIRTHPLACE OF FATHER (State or country) Md.
 12 MAIDEN NAME OF MOTHER Elizabeth Hush
 13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edith Hull
 (Address) 4758 Primlico Rd.

15 Filed 1/31/1915 Harry G. May
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 31, 1915
 (Month) (Day) (Year)
 17 I HEREBY CERTIFY that I attended deceased from July 14, 1915, to Jan 30, 1915,
 that I last saw her alive on Jan 30, 1915,
 and that death occurred on the date stated above, at 2:31 P m.
 The CAUSE OF DEATH* was as follows:

Arteriosclerosis.(Duration) 2 yrs. mos. ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) W. D. Less, M.D., M. D.
Jan 30, 1915 (Address) Arlington Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted,
 If not at place of death?

Former or
 usual residence.

19 PLACE OF BURIAL OR REMOVAL Druid Ridge Bur DATE OF BURIAL Feb 2, 1915
 20 UNDERTAKER Harry W. Ehlert ADDRESS W. Norton

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

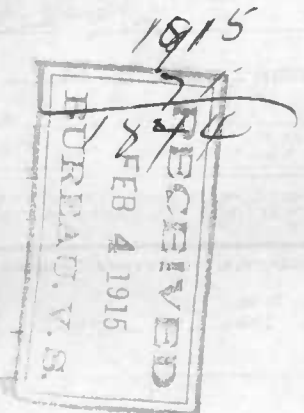
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverter wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH CITY DETENTION HOSPITAL
FOR INSANE

STATE OF MARYLAND
CERTIFICATE OF DEATH

County Baltimore

Registration Dist. No. 41

Village or City Bay View Asylum.

(No. 105)

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Hattie Gibson,

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, Married OR DIVORCED (Write the word)

6 DATE OF BIRTH 1873
(Month) (Day) (Year)

7 AGE 42 yrs. 0 mos. 0 ds. OR 0 min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Virginia

PARENTS
10 NAME OF FATHER ?
11 BIRTHPLACE OF FATHER (State or country) ?
12 MAIDEN NAME OF MOTHER ?
13 BIRTHPLACE OF MOTHER (State or country) ?

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister Mrs. Anna Floyd

(Address) 2726 Hampden Ave

15 Filed Jan 22, 1915 Miriam Barr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 20th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from November 30, 1914 to January 20th, 1915

that I last saw her alive on January 20th, 1915

and that death occurred on the date stated above, at 6.55 P.m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

(Duration) ? yrs. 0 mos. ? ds.

Contributory Ileocolitis
Secondary

(Duration) ? yrs. ? mos. ? ds.

(Signed) Philip Pearlman, M. D.
Jan 21, 1915 (Address) City Detention Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 22 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence 2726 Hampden Ave.

19 PLACE OF BURIAL OR REMOVAL Lancaster County DATE OF BURIAL Jan 22, 1915

20 UNDERTAKER Geo. W. Little ADDRESS 531 N. Church St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

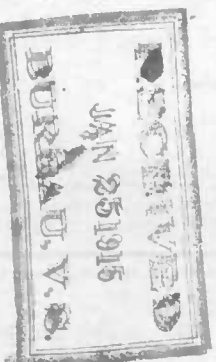
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

237

County

Baltimore

(81)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

38

Village or City

Roland Park

(No.)

306 Woodlawn Road

St.

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Henry Gibson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

Widowed

6 DATE OF BIRTH

December 18th, 1833
(Month) (Day) (Year)

7 AGE

81 yrs. 1 mos. 1 ds.

It LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Pina Cotta

9 BIRTHPLACE

(State or country)

England

PARENTS

10 NAME OF FATHER

Henry Gibson

11 BIRTHPLACE OF FATHER
(State or country)

England

12 MAIDEN NAME OF MOTHER

not known

13 BIRTHPLACE OF MOTHER
(State or country)

England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. J. F. Bartlett

(Address)

214 Roland Ave. Roland Park

15

Filed

Jan. 20, 1915 M. G. Porlin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 19, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Jan - 19, 1915, to Jan - 19, 1915,

that I last saw him alive on Jan - 19, 1915,

and that death occurred on the date stated above, at 9-50 P. m.

The CAUSE OF DEATH* was as follows:

Senile Arterio-sclerosis

(Duration) — yrs. — mos. — ds. 1/3

Contributory
Secondary(Signed) M. G. Porlin, M. D.
Jan. 20, 1915 (Address) Roland Park Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery January 22, 1915

20 UNDERTAKER

ADDRESS

Shewart-Morwin Company 108 W. North Ave.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

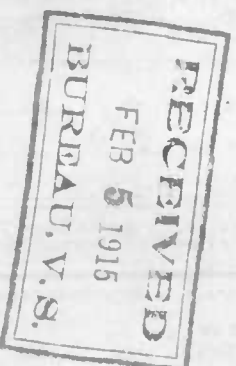
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County BaltimoreVillage or City Bay View Asylum(No. CITY HOSPITAL St.; Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Margaret Gibson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH January 8th, 1863
(Month) (Day) (Year)

7 AGE 52 yrs. 5 mos. 12 ds. If LESS than 1 day, 1 day, 1 hrs. OR 1 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Steven Queen
11 BIRTHPLACE OF FATHER (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15 Filed Jan 21, 1915 M. M. Bann
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 20th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 8th, 1915 to January 20th, 1915

that I last saw h. er alive on January 20th, 1915

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Caecum
(Duration) unknown yrs. 0 mos. 0 ds.

Contributory Secondary

(Signed) H. C. Pinckney, M. D.
Jan. 20, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 12 yrs. 0 mos. 0 ds. In the State 12 yrs. 0 mos. 0 ds.

Where was disease contracted, unknown

If not at place of death? unknown

Former or usual residence Unknown

19 PLACE OF BURIAL OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Jan 22, 1915

20 UNDERTAKER Armstrong-Denny Co. ADDRESS 715 Light St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

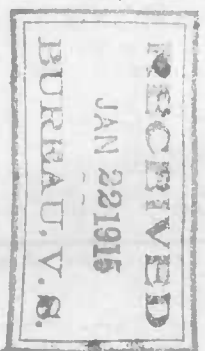
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

239

County

Baltimore

Village or City

Leatonsville

(No.

Spring Grove State Hosp.

Registration Dist. No.

30

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Margaret A. Gibson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fe

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

Mar

20

1899

(Month)

(Day)

(Year)

7 AGE

74

yrs.

9

mos.

20

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Virginia

10 NAME OF FATHER

Henry Barnes

11 BIRTHPLACE OF FATHER (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Eveline Miller

13 BIRTHPLACE OF MOTHER (State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. Barnes

(Address)

Relay, Md.

15

Filed

Jan 9

1915

Marshall B. West

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 9th

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct-24

1910

to

Jan 9th

1915

that I last saw him alive on

Jan 8th

1915

and that death occurred on the date stated above, at

3 a.

m.

The CAUSE OF DEATH* was as follows:

Cerebral Effusion

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Senile Dementia

(Duration)

yrs.

mos.

ds.

(Signed)

J. Berg Knapp

M. D.

Jan 8

1915

(Address)

Cabinville, Md.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

14

yrs.

3

mos.

10

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Baltimore, Md.

19 PLACE OF BURIAL OR REMOVAL

Delaplain, Va.

DATE OF BURIAL

1915

20 UNDERTAKER

M. J. Pickner

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

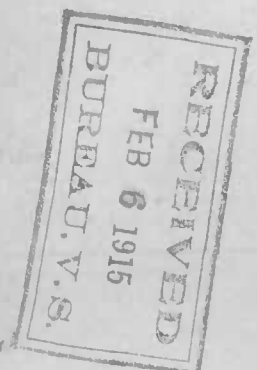
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| | | | |
|--|---------------------------------|---|--|
| 1 PLACE OF DEATH <u>240</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <u>Baltimore</u> | | Registration Dist. No. <u>41</u> | |
| Village or City <u>Bay View Asylum</u> | | CITY HOSPITAL. | |
| (No. _____) | | St.; _____ Ward) | |
| [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | |
| 2 FULL NAME <u>Caroline Gill</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word) | |
| 6 DATE OF BIRTH _____, 18 <u>45</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>70?</u> yrs. _____ mos. _____ ds. OR _____ 1 day, _____ hrs. _____ min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Domestic</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | |
| PARENTS | | | |
| 10 NAME OF FATHER <u>Christopher Waxter</u> | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | | | |
| 12 MAIDEN NAME OF MOTHER <u>Cristena (unknown)</u> | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Europe</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hospital Records</u> (Address) <u>Bay View</u> | | | |
| 15 Filed <u>Jan 18</u> , 191 <u>5</u> <u>Mrs. M. B. Burr</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>January 18th</u> , 191 <u>5</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan. 13th</u> , 191 <u>5</u> , to <u>January 18th</u> , 191 <u>5</u> , that I last saw her alive on <u>January 18th</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>9 A. M.</u> , The CAUSE OF DEATH* was as follows: <u>Chronic Myocarditis</u> (Duration) <u>unknown</u> yrs. _____ mos. _____ ds. <u>Chronic Bronchitis</u> (Duration) <u>unknown</u> yrs. _____ mos. _____ ds. Contributory _____ Secondary _____ (Signed) <u>M. Plucette</u> CITY HOSPITAL, M. D. <u>Jan. 18</u> , 191 <u>5</u> (Address) _____ | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. <u>5</u> ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, <u>unknown</u> If not at place of death? Former or usual residence <u>1213 Hollins St., City.</u> | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Balto. Cemetery</u> | | DATE OF BURIAL <u>Jan 20</u> , 191 <u>5</u> | |
| 20 UNDERTAKER <u>John J. Fields</u> | | ADDRESS <u>1200 W. Lombard</u> | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

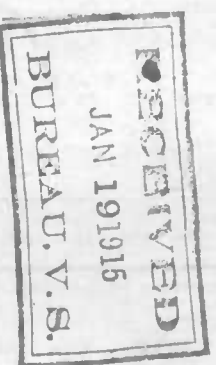
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not painfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 241 # 103 STATE OF MARYLAND
County Baltimore CERTIFICATE OF DEATH

Village or City Udetrille (No. 113 Maple St.; _____ Ward) Registration Dist. No. 142

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rachel Rebecca Gilpin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Wh. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Oct 9, 1846
(Month) (Day) (Year)

7 AGE 68 yrs. 3 mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Leri Pearce

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Kelley

(Address) 113 Maple St.

15 Filed Jan 10, 1915 F. H. Ruhl
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 9th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Heart Failure

Contributory (Secondary) Acute Indigestion
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Louis John Gorman, M. D.
Jan 9th, 1915. (Address) Halethorpe Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St Marys Cem DATE OF BURIAL 1-12, 1915

20 UNDERTAKER Wm Cook ADDRESS North Greenmount Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

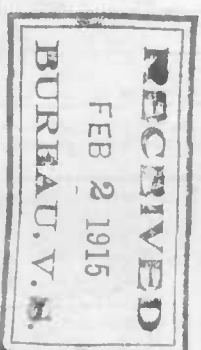
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative *healthfulness* of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Stas-mus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County BaltimoreVillage or City St. Agnes Hospital

2 FULL NAME

Lottie Goechi Glass

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 28, 1904
(Month) (Day) (Year)

7 AGE 10 yrs. 5 mos. 26 ds. OR 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore, Md.

PARENTS
10 NAME OF FATHER Ernest Goechi
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER Emma Baer
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Glass(Address) 401 Furrow Street

15 Filed Jan 23, 1915 H. H. Loos
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 142

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 23, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1915 to Jan 23, 1915

that I last saw her alive on Jan 23, 1915

and that death occurred on the date stated above, at 9:10 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia (organism not known).
Acute Appendicitis Operation 13 days ago

(Duration) 15 yrs. 15 mos. 15 ds.

Contributory Acute nephritis, broncho-pneumonia
Secondary peritonitis

(Duration) 13 yrs. 13 mos. 13 ds.

(Signed) E. H. Oster, M. D.
Jan 23, 1915 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 13 yrs. 13 mos. 13 ds. In the State 13 yrs. 13 mos. 13 ds.

Where was disease contracted, If not at place of death?

Former or usual residence 401 Furrow Street

19 PLACE OF BURIAL OR REMOVAL Western Cemetery DATE OF BURIAL 1915

20 UNDERTAKER Fred Wippert ADDRESS 1 Fred Ave. Ext.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

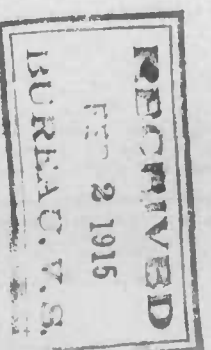
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH

243

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highlandtown

(No.)

3611 Foster Ave.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Anna May Goetz

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

Married

DATE OF BIRTH

April 10, 1862

(Month) (Day) (Year)

AGE

52 yrs.

8 mos.

29 ds.

IF LESS than

1 day, hrs.

OR min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(State or country)

Baltimore City.

PARENTS

10 NAME OF FATHER

Thomas Gebhardt.

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Gebhardt.

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Christopher Goetz

(Address)

3611 Foster Ave

15

Filed

Jan. 13, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 9th, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 5, 1915, to Jan. 9th, 1915.that I last saw her alive on Jan. 8th, 1915.

and that death occurred on the date stated above, at 1:55 A.M.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

Long (Duration) yrs. mos. 5 ds.

Contributory
Secondary

Pneumonia (Duration) yrs. 6 mos. ds.

(Signed) C. W. Meyer, M. D.

Jan. 11, 1915 (Address) 100 S. Pratt Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Holy Redeemer Ch.

DATE OF BURIAL

Jan. 13, 1915

20 UNDERTAKER

Lily & Co. Zieher.

ADDRESS

403 S. W. 10th St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

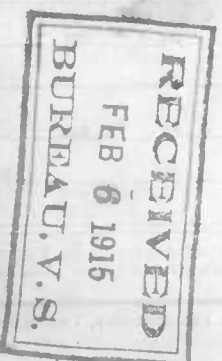
[Approved by U. S. Census and American Public Health Association.]

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244

(28)

1 PLACE OF DEATH

County Baltimore, Md

Village or City Bay View Asylum (No. _____, St. _____ Ward _____)

Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Fayette Green

| PERSONAL AND STATISTICAL PARTICULARS | | | | MEDICAL CERTIFICATE OF DEATH | |
|---|---|--|--|--|--|
| 3 SEX <u>male</u> | 4 COLOR OR RACE <u>negro</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Separated</u> | | 16 DATE OF DEATH <u>Jan 5</u> , 191 <u>5</u> (Month) (Day) (Year) | |
| 6 DATE OF BIRTH _____, 18 <u>68</u> (Month) (Day) (Year) | | | | 17 I HEREBY CERTIFY, That I attended deceased from <u>Dec 16</u> , 191 <u>4</u> , to <u>Jan 5</u> , 191 <u>5</u> that I last saw him alive on <u>Jan 5</u> , 191 <u>5</u> and that death occurred on the date stated above, at <u>6:30 P.m.</u> The CAUSE OF DEATH* was as follows: <u>Phthisis pulmonalis</u> (Duration) _____ yrs. <u>3</u> mos. _____ ds. | |
| 7 AGE <u>47</u> yrs. _____ mos. _____ ds. OR _____ min. ? If LESS than 1 day, _____ hrs. | | | | Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>mail carrier</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | | | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. <u>20</u> ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? <u>Asylum</u> Former or usual residence <u>661 Ume St.</u> | |
| PARENTS | 10 NAME OF FATHER <u>Wm. Green</u> | | | (Signed) <u>F. F. Callahan</u> , M. D. <u>Jan 5</u> , 191 <u>4</u> . (Address) <u>City St Hospital</u> | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Katie Mackey</u> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hospital Records</u> (Address) <u>Bay View</u> | | | | | |
| 15 Filed <u>Jan 6th</u> , 191 <u>5</u> <u>Mrs. Sam Bow</u> REGISTRAR | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Mt. Auburn Cemetery</u> | | | | DATE OF BURIAL <u>Jan 8</u> , 191 <u>5</u> | |
| 20 UNDERTAKER <u>Alfred J. Ireland</u> | | | | ADDRESS <u>1147 N. Schode</u> <u>St.</u> | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer" etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Scutle" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverter wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



PLACE OF DEATH

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 38Village or City Towson (No. _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Mrs. Philipp Green

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)6 DATE OF BIRTH Oct 2, 1914
(Month) (Day) (Year)7 AGE 3 yrs. 3 mos. — ds. If LESS than 1 day, _____ hrs. OR _____ min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Harry Green11 BIRTHPLACE OF FATHER (State or country) Not known12 MAIDEN NAME OF MOTHER Mary Scoville13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Scoville(Address) Towson15 Filed Jan 6, 1915 Clara Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 5th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1915 to Jan 5th, 1915
that I last saw him alive on Jan 4th, 1915and that death occurred on the date stated above, at 1 p. m.
The CAUSE OF DEATH* was as follows:Pneumonia(Duration) _____ yrs. _____ mos. 4 ds.Contributory Exhaustion
(Secondary)(Duration) _____ yrs. _____ mos. 4 ds.(Signed) H. J. Jarrett, M. D.Jan 5th, 1915 (Address) Towson, Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, It not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Pleasant Rest Cem. DATE OF BURIAL Jan. 7, 191520 UNDERTAKER John Burns Sons ADDRESS Towson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 5 1915
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Baltimore

246

(92)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

11

Village or City

Highlandtown

(No.)

*716**S. Fourth St.*

St.;

Ward)

St.;

Ward)

St.;

Ward)

St.;

Ward)

St.;

Ward)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Helen E. Guss

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

March 7, 1914

(Month)

Day

(Year)

7 AGE

10 yrs.

mos.

7 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore Co.

PARENTS

10 NAME OF FATHER

John Guss

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Veronica Schmidt

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Guss

(Address)

716 S. Fourth St.

15

Filed

Feb 2

1915

W. E. McLaughlin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 31, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 22, 1915

to

Jan. 31, 1915

that I last saw her alive on

*Jan. 31, 1915*and that death occurred on the date stated above, at *10.30* m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) — yrs. — mos. — ds.

Contributory Secondary

Lobular pneumonia

(Duration) — yrs. — mos. — ds.

(Signed)

*J. J. Pelela, M. D.**Feb. 1, 1915*

(Address)

101 S. Disgrace St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

to the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

Holy Redeemer Ch.

DATE OF BURIAL

Feb. 2, 1915

20 UNDERTAKER

Lily E. G. J. J.

ADDRESS

403 S. Wolfe

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*; *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fidental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæ-mia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAR 4 1915

BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

247

County

Balto.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 40

Village or City

Fork

(No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Laura V. Hall

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

June 4, 1856
(Month) (Day) (Year)

7 AGE

58 yrs. 7 mos. 5 ds. It LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md.

PARENTS

10 NAME OF FATHER

Hesley Knight

11 BIRTHPLACE OF FATHER

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

Miss Foord

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert Hall

(Address)

Fork Md.

15

Filed

Jan 11, 1915 - J. F. Fox

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 9, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 4, 1915, to Jan 9, 1915.

that I last saw her alive on Jan 9, 1915.

and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) ____ yrs. ____ mos. 6 ds.

Contributory
Secondary

Heart failure

(Duration) ____ yrs. ____ mos. 2 ds.

(Signed)

John S. Green, M. D.

Jan 11, 1915 (Address) Ellettsville, Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chestnut Grove Cemetery Jan 12, 1915

20 UNDERTAKER

ADDRESS

John Arthur Foon Fork, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

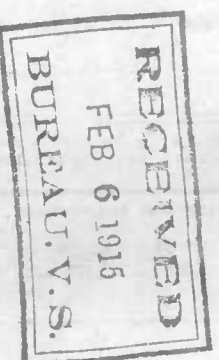
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore

248

(64)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

Village or City

Bay View Asylum

(No.)

CITY HOSPITAL.

St.; Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]2 FULL NAME Thomas Hall

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black5 SINGLE, MARRIED, WIDDED, OR DIVORCED
(Write the word)
Single

6 DATE OF BIRTH

1837
(Month) (Day) (Year)

7 AGE

78 yrs. mos. ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Farm laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

James Hall

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

II

13 BIRTHPLACE OF MOTHER

(State or country)

II

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Bay View

15

Filed

Jan 8, 1915Miriam Baer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 6th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

December 11, 1914 to January 6th, 1915that I last saw him alive on January 6th, 1915and that death occurred on the date stated above, at 12.30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis(Duration) unknown yrs. mos. ds.Contributory
Secondary(Duration) unknown yrs. mos. ds.(Signed) M. Phillips, M. D.Jan. 6th, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 25 yrs. mos. ds. In the State 4 yrs. mos. ds.Where was disease contracted,
If not at place of death?Former or usual residence Lombard St., 4

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Johns Hopkins Hospital Dec 8, 1915

20 UNDERTAKER

ADDRESS

H. L. Hawley 1109 N. Elmer

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetania," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Balto.

249

(69)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

38

Village or City

Roland Park

(No.

305 Edgerale Rd

St;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John A. Hanna

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

March 4

1889

(Month)

(Day)

(Year)

7 AGE

25

yrs

10

mos

22

ds

If LESS than 1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

J

9 BIRTHPLACE

(State or country)

Belair Md

PARENTS

10 NAME OF FATHER

John B. Hanna

11 BIRTHPLACE OF FATHER (State or country)

Belair md

12 MAIDEN NAME OF MOTHER

Martha Standiford

13 BIRTHPLACE OF MOTHER (State or country)

Harford Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John B. Hanna

(Address)

305 Edgerale Rd

15

Filed

Jan 27

1915

Roland Park

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan

26th

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 26th

1915

to

Jan 26th

1915

that I last saw him alive on

Jan 26th

1915

and that death occurred on the date stated above, at 12:35 P.m.

The CAUSE OF DEATH* was as follows:

Epilepsy, frequent convulsions, began since childhood. (Duration) yrs. mos. ds.

Contributory Secondary Exhaustion (Duration) yrs. mos. ds.

(Signed) Charles Bagley, M. D.
Jan 27, 1915 (Address) 1515 Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Belair Harford Co Md

Jan 28, 1915

20 UNDERTAKER

ADDRESS

John C. Hough Co

Punnsan

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto. Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

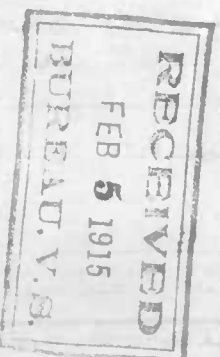
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not finally employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Baltimore

Village or City Lansville (No. Ind)

2 FULL NAME Mary Ann Kantonen

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH 12 4, 1880
(Month) (Day) (Year)

7 AGE 74 yrs. 1 mos. — ds. OR LESS than 1 day, — hrs. — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm. Dawson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Malony

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Nichols
(Address) Lansville Ind

15 Filed Jan 7, 1915 M. F. Clayton

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 4, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to Jan 4, 1915, that I last saw her alive on Jan 4, 1915.

and that death occurred on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis
(Duration) 8 yrs. — mos. — ds.

Contributory Chronic Nephritis
Secondary
(Duration) 5 yrs. — mos. — ds.

(Signed) George L. King, M. D.
Jan 4, 1915 (Address) Hamilton Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore Cemetery DATE OF BURIAL Jan 8th, 1915

20 UNDERTAKER Fredrick L. L. L. ADDRESS Fullerton Ind.

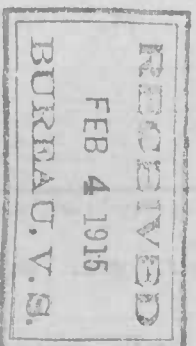
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Baltimore

Village or City Catonsville

(No. _____)

St.; _____ Ward)

Registration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles Westley Hardester

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

Unk.

6 DATE OF BIRTH

Unk Unk Unk
(Month) (Day) (Year)

7 AGE

71 yrs. — mos. — ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Tramf. for 16 yrs.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Unk

PARENTS

10 NAME OF FATHER

Unk

11 BIRTHPLACE OF FATHER (State or country)

Unk

12 MAIDEN NAME OF MOTHER

Unk

13 BIRTHPLACE OF MOTHER (State or country)

Unk

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Catonsville Police Station

(Address)

Catonsville Md

15

Filed

Jan 7 1915

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 6, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 4, 1915, to Jan 6, 1915,
that I last saw him alive on Jan 6, 1915and that death occurred on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Infinitus of Age

(Duration) yrs. mos. ds.

Contributory
SecondaryBronch. Pneumonia

(Duration) yrs. mos. ds.

(Signed)

Marshall Brust

, M. D.

Jan 7, 1915 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salem Lutheran ChJan 8, 1915

20 UNDERTAKER

ADDRESS

Mrs C Preston & SonCatonsville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

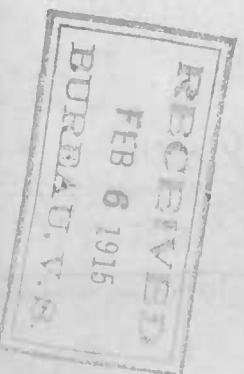
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County

Baltimore

252

(64)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highland

(No. 501 S. 12th

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Jack Havaland

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

w

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6 DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7 AGE

About 45 yrs.

mos.

ds.

It LESS than

1 day.....hrs.

OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

unknown

PARENTS

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (State or country)

unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

None

(Address)

15

Filed

Jan 12, 1915

W. E. W. Clausen M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1

12

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

....., 191....., to....., 191.....,

that I last saw him..... alive on....., 191.....

and that death occurred on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)

yrs.

mos.

ds.

Contributory

Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

J. S. Marston

, M. D.

Jan 12, 1915

(Address)

corner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

2334 Jefferson St

Jan 12, 1915

20 UNDERTAKER

ADDRESS

Christina Miller

2334 Jefferson St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

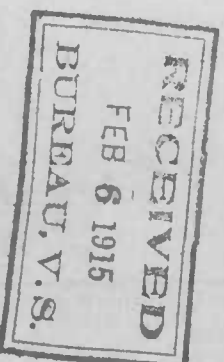
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Turner (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

253

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 83Village or City Woodensburg (No. _____) St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Margaret Dickson Henkle

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 MARRIAGE STATUS WIDOWED
(Write the word)

6 DATE OF BIRTH

Unknown, 1835
(Month) (Day) (Year)

7 AGE

81 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Ind

PARENTS

10 NAME OF FATHER

John Jones

11 BIRTHPLACE OF FATHER (State or country)

Ind

12 MAIDEN NAME OF MOTHER

Margaret Dickson

13 BIRTHPLACE OF MOTHER (State or country)

Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Margaret Jones

(Address)

Woodensburg

15

Filed

Jan 19th 1915Joett Wilson
Sept 2nd REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 17, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

for several years, 1915that I last saw her alive on 12 day of Jan, 1915and that death occurred on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis3 or 4 days

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

Softening of Brain(Duration) 5 yrs. _____ mos. _____ ds.

(Signed)

Joett Wilson

M. D.

Jan 17th 1915

(Address)

Woodensburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Kildad CemeteryJan 19th 1915

20 UNDERTAKER

ADDRESS

Joett WilsonRegisterston

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is unnecessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congitital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH Baltimore
County Baltimore

254

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 32

Village or City Arlington (No. 5305 Main) St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Elizabeth Jane Hensel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Nov 20, 1869
(Month) (Day) (Year)

7 AGE 45 yrs. 1 mos. 19 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md.

10 NAME OF FATHER John Eckstein

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Annie Briers

13 BIRTHPLACE OF MOTHER (State or country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry A. Eckstein

(Address) 2005 Arlington Rd

15 Filed Jan 10, 1915 Wm. G. Queen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 9, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h..... alive on..... 191.....

and that death occurred on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows: Chronic Injured
Artery, she came to her death at
5305 Main St. Arlington by a postal
fire from her own hand Jan 9
1915 (Duration)..... yrs..... mos..... ds.

Contributory (Secondary)

(Signed) John J. Hensel, M.D.

, 191..... (Address) Arlington Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Druid Ridge DATE OF BURIAL Jan 12, 1915

20 UNDERTAKER William Cook ADDRESS 5016 North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

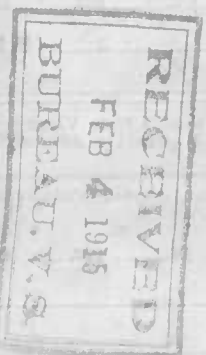
Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

255

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 40Village or City Glenarm (No. 65) St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Nancy Jane Hertzler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH March 3rd, 1857
(Month) (Day) (Year)

7 AGE 57 yrs. 10 mos. 16 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Maryland

PARENTS

10 NAME OF FATHER John Q. Miller11 BIRTHPLACE OF FATHER
(State or country) Pennsylvania12 MAIDEN NAME OF MOTHER Barbara Riehl13 BIRTHPLACE OF MOTHER
(State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Hertzler(Address) Glenarm Md15 File Jan 20, 1915 A. F. Hertzler

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 19th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1912 to Jan 11, 1915, that I last saw her alive on Jan 11, 1915

and that death occurred on the date stated above, at HA m.

The CAUSE OF DEATH* was as follows:

Softening of Brain from some unknown cause, most likely Embolus
(Duration) 3 yrs. mos. ds.

Contributory
Secondary(Duration) yrs. mos. ds.

(Signed) John S. Green, M. D.
Jan. 20, 1915 (Address) Sittings, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Memnonite Cemetery
Long Green Md.

DATE OF BURIAL

Jan. 21st, 1915

20 UNDERTAKER

Slade Bros.

ADDRESS

Long Green Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

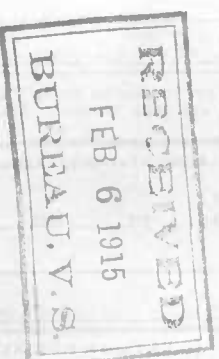
[Approved by U. S. Census and American Public Health
Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

256

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Bay View Asylum. (No. 91 CITY HOSPITALSt.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ariamra Hewes

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH

1-834
(Month) (Day) (Year)

7 AGE

81

yrs.

mos.

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Samuel Whitlock

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Elizabeth Whitlock

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Bay View

15

Filed

Jan 27, 1915
M. M. B. Carr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 27th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
January 11th 1915 to January 27th, 1915.that I last saw h. er alive on January 27th, 1915.and that death occurred on the date stated above, at 1.30 Am.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(Duration) yrs. 7 mos. 7 ds.Contributory
SecondaryFracture Femur (R)(Duration) yrs. 7 mos. 7 ds.(Signed) W. Houston Boulton, M. D.Jan. 27th, 1915. (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 16 yrs. 16 mos. 16 ds. In the State 16 yrs. 16 mos. 16 ds.Where was disease contracted,
If not at place of death?Former or usual residence Bayview Asylum (5 yrs. 4m-13 d)

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balto. Cemetery Jan 27, 1915

20 UNDERTAKER

ADDRESS

Wm. Cook 502 E. North

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

are.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

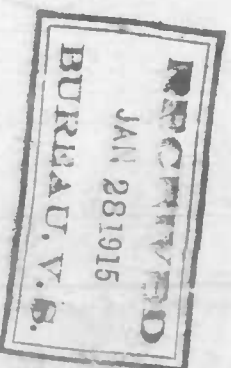
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

257

County

Baltimore

Village or City

Reeay

(No.

St; Ward)

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

(The Rev) Hobbs

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Jan. - 17 - 1915
(Month) (Day) (Year)

7 AGE

Shree Bann

If LESS than 1 day, 6 hrs. OR 5 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Md

10 NAME OF FATHER

Alexander Hobbs

11 BIRTHPLACE OF FATHER (State or country)

Md

12 MAIDEN NAME OF MOTHER

Sister Poole

13 BIRTHPLACE OF MOTHER (State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

The S. Hobbs

(Address)

Reeay, Md.

15

Filed

Jan. 19, 1915 J. H. Ruhl

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 17, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Shree Bann

(Duration) yrs. mos. ds.

Contributory (Secondary)

Pulmonary tuberculosis

(Signed)

J. H. Ruhl, M. D.
Jan 17, 1915 (Address) Reeay, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

At home place (Reeay)

Jan 17, 1915

20 UNDERTAKER

ADDRESS

None

Reeay

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

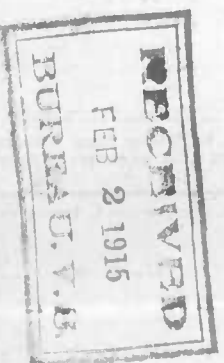
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is inadmissible); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

258

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Bay View Asylum.

(No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Hodges

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow.
(Write the word)

6 DATE OF BIRTH

1862
(Month) (Day) (Year)

7 AGE

53 yrs. _____ mos. _____ ds. OR _____ mn. ?
It LESS than 1 day, _____ hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Factory worker

9 BIRTHPLACE (State or country)

Maryland.

PARENTS

10 NAME OF FATHER

Frank Busick

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records
Bay View

(Address)

15

Filed Jan 26, 1915 M. E. Baer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 26, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Oct. 13, 1914, to Jan. 26, 1915.that I last saw him alive on Jan. 26, 1915and that death occurred on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis(Duration) 1 yr. 6 mos.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F. F. Callahan, M. D.Jan 26, 1915. (Address) City, Ill. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. 3 mos. 13 ds. In the State Ill. yrs. _____ mos. _____ ds.Where was disease contracted, UnknownFormer or usual residence 2038 Fountain St.

19 PLACE OF BURIAL OR REMOVAL

Oaklawn Cemetery DATE OF BURIAL Jan 29, 1915

20 UNDERTAKER

Wm Cook ADDRESS 582 E. Northare

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

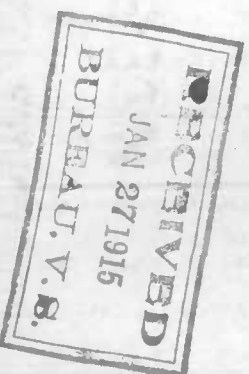
[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Baltimore 259
Village or City Riderwood (No. 40) St.; Ward)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Hoff

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 10, 1847
(Month) (Day) (Year)

7 AGE 67 yrs. 6 mos. 1 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Clerical
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Rev. Geo. F. Hoff D. D.
11 BIRTHPLACE OF FATHER (State or country) Lancaster Pa.
12 MAIDEN NAME OF MOTHER Juliana J. Ross
13 BIRTHPLACE OF MOTHER (State or country) Frederick Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. W. Hoff
(Address) Riderwood Md.

15 Filed Jan. 13, 1915 S. M. G. Porter
REGISTRAR

If more blanks are needed, address State Registrar, 602 Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 11, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from about Jan'y, 1914, to Jan'y 11, 1915.

that I last saw him alive on Jan'y 11, 1915.

and that death occurred on the date stated above, at about 8 P.M.

The CAUSE OF DEATH*, was as follows:
Carcinoma of Stomach

Contributory
Secondary
(Duration) abt. yrs. 1 mos. 1 ds.

(Signed) Wm. L. Lockwood, M. D.
Jan'y 12, 1915 (Address) 8 E. Capitol St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 43 yrs. 2 mos. 11 ds. In the State 56 yrs. 5 mos. 1 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Frederick Md DATE OF BURIAL Jan'y 13, 1915

20 UNDERTAKER Henry W. Jenkins ADDRESS Orchard

Alvin H. Lockwood.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

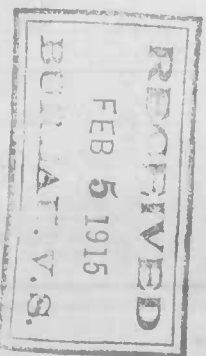
[Approved by U. S. Census and American Public Health
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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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| 1 PLACE OF DEATH | | 260 | | STATE OF MARYLAND | |
|---|-----------------|--|--|---|--|
| County | | (S) | | CERTIFICATE OF DEATH | |
| Village or City | | (No. Maryland Ave.) | | Registration Dist. No. 42. | |
| 2 FULL NAME | | Infant Hoffman (2 mo) | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | | | |
| male | white | infant | | | |
| 6 DATE OF BIRTH | | 7 AGE | | | |
| Jan 2, 1915 | | If LESS than 1 day, hrs. yrs. mos. ds. OR min. ? | | | |
| 8 OCCUPATION | | 9 BIRTHPLACE | | | |
| (a) Trade, profession, or particular kind of work | | (State or country) | | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | | Mich | | | |
| 10 NAME OF FATHER | | 11 BIRTHPLACE OF FATHER | | | |
| Halbert Hoffman | | Mich | | | |
| 12 MAIDEN NAME OF MOTHER | | 13 BIRTHPLACE OF MOTHER | | | |
| Gussie Kalnie | | Mich | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | |
| (Informant) Halbert Hoffman | | | | | |
| (Address) Westport | | | | | |
| 15 FILED Jan 4 1915 F. J. Ruhl | | | | | |
| REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH Jan 2, 1915 | | | | | |
| 17 I HEREBY CERTIFY That I attended deceased from Jan 2, 1915 to Jan 2, 1915 | | | | | |
| that I last saw him alive on Jan 2, 1915 | | | | | |
| and that death occurred on the date stated above, at 5 m. | | | | | |
| The CAUSE OF DEATH* was as follows: | | | | | |
| Premature Birth (2 mo) | | | | | |
| (Still-Born) (Duration) yrs. mos. ds. | | | | | |
| Contributory Secondary | | | | | |
| (Duration) yrs. mos. ds. | | | | | |
| (Signed) Raymond S. Kline, M. D. | | | | | |
| Jan 4, 1915 (Address) Westport | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | |
| At place of death yrs. mos. ds. In the State yrs. mos. ds. | | | | | |
| Where was disease contracted, If not at place of death? | | | | | |
| Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL | | | | | |
| Ladysville Jan 5, 1915 | | | | | |
| 20 UNDERTAKER ADDRESS | | | | | |
| Hallert Hoffman Westport | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

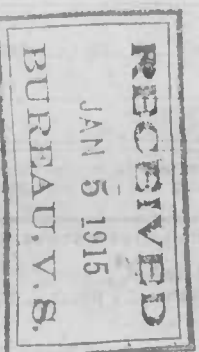
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

1 PLACE OF DEATH

County BaltoVillage or City Highlandtown(No. 3518 E. Baltimore

St.; Ward)

2 FULL NAME Catherine C. Hofstetter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married
(Write the word)6 DATE OF BIRTH Aug 21, 18747 AGE 40 yrs. 4 mos. 25 ds.If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work House work(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country) Md10 NAME OF
FATHER Joseph A. Forester11 BIRTHPLACE
OF FATHER
(State or country) Md12 MAIDEN NAME
OF MOTHER Mary E. Smith13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Frederick Hofstetter(Address) 3518 E. Baltimore St

15

Filed Jan 16, 1915REGISTRAR W. M. Cloonan

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 15, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from
Jan 4, 1915 to Jan 15, 1915that I last saw her alive on Jan 14, 1915and that death occurred on the date stated above, at 5:40 a.m.

The CAUSE OF DEATH* was as follows:

Accidental poisoning
with - Micheneride of Mercury
taken first at St. Joseph's Hospital
for about 9 days.
(Duration) yrs. mos. 20 ds.Contributory
Secondary Arterio-sclerosisUnknown (Duration) yrs. mos. ds.(Signed) E. B. MillerJan 15, 1915 (Address) 1715 E. Park St*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery Jan 18, 1915

20 UNDERTAKER

ADDRESS

Christian Miller 2334 Jefferson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

262

81

STATE OF MARYLAND
CERTIFICATE OF DEATH

County.....Baltimore.....

Registration Dist. No. 41

Village or City Bay View Asylum (No. CITY HOSPITAL St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME.....Samuel Hopley.....

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|----------------------|---------------------------------|---|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u> |
|----------------------|---------------------------------|---|

6 DATE OF BIRTH.....1834.....
(Month) (Day) (Year)7 AGE.....81.....
yrs. mos. ds. 1 LESS than 1 day, hrs. ? OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work.....Engineer
(b) General nature of industry, business, or establishment in which employed (or employer).....9 BIRTHPLACE
(State or country).....England.....10 NAME OF FATHER.....Wm. Hopley.....11 BIRTHPLACE OF FATHER
(State or country).....England.....12 MAIDEN NAME OF MOTHER.....Margaret Loyd.....13 BIRTHPLACE OF MOTHER
(State or country).....England.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....Hospital Records.....(Address).....Bay View.....15 Filed Jan 5, 1915 Murphy Bar.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH.....January 4th, 1915.....
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Dec. 2nd, 1914, to January 4th, 1915.that I last saw him alive on January 4th, 1915.and that death occurred on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Senility
(Duration) unknown yrs. mos. ds.
Contributory Arteriosclerosis
Secondary (Duration) unknown yrs. mos. ds.
(Signed) M. H. Hopp, M. D.
Jan. 4th, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 1 mos. 2 ds. In the State yrs. mos. ds.Where was disease contracted, unknown
If not at place of death?Former or usual residence. 307 S. Sharp St.19 PLACE OF BURIAL OR REMOVAL.....Oak Lawn Cem..... DATE OF BURIAL.....Jan. 6th, 1915.....20 UNDERTAKER.....Albert E. Tuller..... ADDRESS.....221 N. Bdwg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

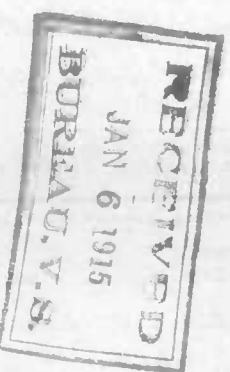
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH
County Baltimore

Village or City Montebello Park, Woodland Ave (No. _____ St.; _____ Ward)

2 FULL NAME Wm. J. Horn, Jr.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan. 19, 1915
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. OR _____ min. ?
If LESS than 1 day, 5 hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Montebello Park, Baltimore Co. Md.

10 NAME OF FATHER William J. Horn

11 BIRTHPLACE OF FATHER (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margie May Snyder

13 BIRTHPLACE OF MOTHER (State or country) Down

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm J Horn

(Address) Montebello Park

15 Filed Jan 22, 1915 Claud Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 19, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1915, to Jan. 19, 1915.

that I last saw him alive on Jan. 19, 1915

and that death occurred on the date stated above, at 7:30 P.m.

The CAUSE OF DEATH* was as follows:

about 1 month pneumonia
and intercurrent malnutrition

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. Grand, M. D.

Jan. 20, 1915 (Address) 14 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Marys Em. Jan 20, 1915

20 UNDERTAKER ADDRESS

E. Roy Stupples 844 N 36th

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

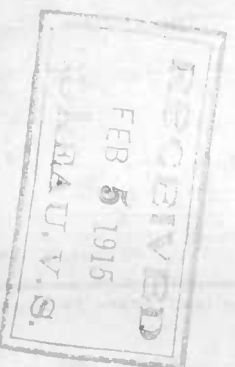
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| 1 PLACE OF DEATH | | | 264 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|--|---|--|---|--|---|--|
| County <u>Baltimore</u> | | | (91) | | Registration Dist. No. <u>41</u> | |
| Village or City <u>Highlandtown</u> | | | (No. <u>306 S. Clinton</u>) | | St.; _____ Ward) | |
| 2 FULL NAME <u>Thomas Jerome Hudgins</u> | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word) | | | | |
| 6 DATE OF BIRTH <u>Dec. 10, 1914</u> (Month) (Day) (Year) | | | | | | |
| 7 AGE _____ yrs. _____ mos. _____ ds. OR _____ min. ? If LESS than 1 day, _____ hrs. | | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | | |
| 9 BIRTHPLACE (State or country) <u>Baltimore Co.</u> | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Wiles Hudgins</u> | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u> | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Rose Saners</u> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore City</u> | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Rose Hudgins</u> (Address) <u>306 S. Clinton St.</u> | | | | | | |
| 15 FILED <u>Jan. 14, 1915</u> <u>4 W. E. M. Clavahan</u> REGISTRAR <u>710</u> | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | |
| 16 DATE OF DEATH <u>Jan. 11, 1915</u> (Month) (Day) (Year) | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred on the date stated above, at <u>8:10 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Pulmonary edema</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>Branch Pneumonia</u> Secondary (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>St. J. Sudler</u> M. D. <u>Jan. 11, 1915</u> (Address) <u>3523 E. Baltimore</u> | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____ | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Rd. Holy Cross Cem. Hampd.</u> DATE OF BURIAL <u>Jan. 14, 1915</u> | | | | | | |
| 20 UNDERTAKER <u>W. E. M. Clavahan</u> ADDRESS <u>403 S. Wolfe</u> | | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

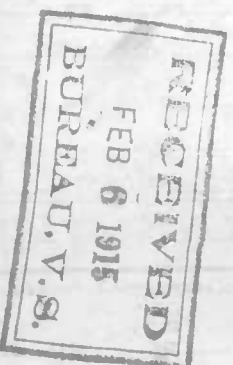
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know—(a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Jaundition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

265

County

Baltimore

Village or City

Glenview

(No.)

St.;

Ward)

Registration Dist. No. 39

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John B. Hutchins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

May 30, 1834

7 AGE

80 yrs. 7 mos. 8 ds.

If LESS than 1 day, hrs. ? OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farm Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore CO

PARENTS

10 NAME OF FATHER

Jarrett Hutchins

11 BIRTHPLACE OF FATHER

(State or country)

Baltimore CO

12 MAIDEN NAME OF MOTHER

Mary Martha Hamm

13 BIRTHPLACE OF MOTHER

(State or country)

Philadelphia PA

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. Hutchins

(Address)

Market Ind

15

Filed

Jan. 11, 1915 Thos. H. Emory

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 11, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 11, 1915 to Jan 11, 1915

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Exhaustion due to exposure
from cold on Jan 7/15
being found dead in snow
field, frozen. (Duration) yrs. mos. ds.

Secondary
Disease of Coronary Artery
located in Wilhelm Corner
(Duration) yrs. mos. ds.

(Signed) R. M. Shuman, M. D.

Jan 11, 1915 (Address) Sparks Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. James P.E. Church, Manor?

Jan 12, 1915

20 UNDERTAKER

ADDRESS

W. C. Brooks Sparks, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

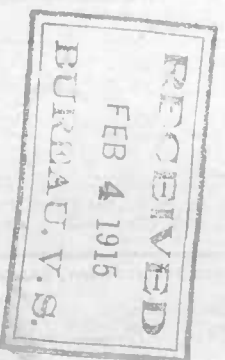
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Tumefaction," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore

266

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City Roland Park (No. 320, Forest Road St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Caroline ^{AME} Synniglowe Janney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH January 1st, 1935
(Month) (Day) (Year)

7 AGE 80 yrs. 0 mos. 7 ds. IF LESS than
1 day.....hrs. OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Baltimore County

10 NAME OF FATHER Thos. Synniglowe
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Angeline Stewart
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Shirley S. Janney

(Address)

1214 Bldg. Baltimore

15

Filed

Jan. 7, 1915

REGISTRAR

If more blanks are needed, address State Registrar, C. E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 7, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Oct - 1 -, 1914, to Jan. 7, 1915.

that I last saw her alive on Jan - 6, 1915

and that death occurred on the date stated above, at 5-30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) 1 yrs. 1 mos. — ds.Contributory
SecondaryMyocarditis(Duration) 3 yrs. 7 mos. 7 ds.

(Signed) M. Gibson Porter, M. D.
Jan. 7, 1915 (Address) Roland Park Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Darlington Cemetery
Barlington Harford Co. Md.

DATE OF BURIAL

Jan. 9, 1915

20 UNDERTAKER

Wm. J. Jenkins & Sons Co
Richard Str.

320 Tolson Recd. 11/1/1919

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

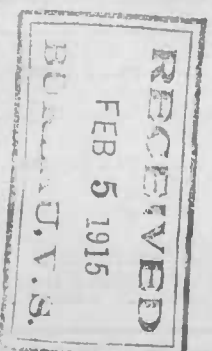
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scabs*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Baltimore

Village or City

Towson

(No.

2 FULL NAME

Thomas Risteau Jenifer

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

38

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W.

5 SINGLE,
MARRIED,
WIDOWED,
OR SEPARATED
(Write the word)

married.

6 DATE OF BIRTH

March 19th, 1854
(Month) (Day) (Year)

7 AGE

60 yrs. 9 mos. 14 ds. It LESS than 1 day.....hrs. OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

Court clerk.

9 BIRTHPLACE
(State or country)

Rock Raven Md.

PARENTS

10 NAME OF FATHER

Daniel Jenifer

11 BIRTHPLACE OF FATHER
(State or country)

Chas. Co. Md.

12 MAIDEN NAME OF MOTHER

Mary Risteau

13 BIRTHPLACE OF MOTHER
(State or country)

Baltimore Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daniel & M. Thos. Jenifer

(Address)

Towson Md.

15

Filed

Jan 2, 1915

Charles Jenifer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 1, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 1913, to Jan 1st, 1915,

that I last saw him alive on Jan 1st, 1915

and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(Duration) 1 yrs. 6 mos. ds.

Contributory
(Secondary)

Arterio Sclerosis

(Duration) 1 yrs. 6 mos. ds.

(Signed)

Daniel & M. Thos. Jenifer, M. D.

Jan 1st, 1915 (Address) Towson, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prospect Hill Cem.

Jan 1st, 1915

20 UNDERTAKER

ADDRESS

John Burns Sons

Towson

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

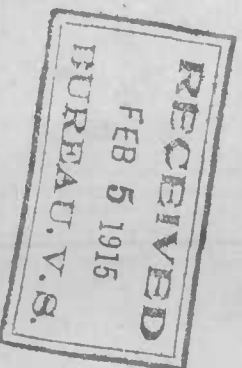
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

268

County BaltimoreVillage or City Bay View

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Henry Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

negro5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)single

6 DATE OF BIRTH

1889
(Month) (Day) (Year)

7 AGE

26 yrs. mos. ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Deck Hand on

(b) General nature of industry, business, or establishment in which employed (or employer)

Steamer

9 BIRTHPLACE

(State or country)

W. Virginia

10 NAME OF FATHER

Deer Johnson

11 BIRTHPLACE OF FATHER

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Margaret Banks

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Bay View

15

Filed

Jan 29, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 28, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec 12, 1914, to Jan 28, 1915.that I last saw him alive on Jan 28, 1915and that death occurred on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis(Duration) 1 yrs. 3 mos. ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) F. F. Callahan M. D.Jan 28, 1915. (Address) City St Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 1 mos. 13 ds. In the State yrs. mos. ds.Where was disease contracted, If not at place of death? UnknownFormer or usual residence 107 W Hughes St

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred Heart 1/29, 1915

20 UNDERTAKER

ADDRESS

Chas. F. Coates & Son 118 Wm Royal

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misadventure as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | |
|--|--|-------------|--|---|--|
| 1 PLACE OF DEATH, <u>Baltimore</u> | | 269 | | STATE OF MARYLAND | |
| County <u>Baltimore</u> | | (103) | | CERTIFICATE OF DEATH | |
| Village or City <u>Cockeysville Md</u> | | (No. _____) | | Registration Dist. No. <u>34</u> | |
| 2 FULL NAME <u>Mollie Johnson</u> | | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |

| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | | |
|---|--|--|---|--|--|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u> | 16 DATE OF DEATH <u>Jan 15</u> , 191 <u>5</u> (Month) (Day) (Year) | | |
| 6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year) | | | 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 9</u> , 191 <u>5</u> , to <u>Jan 15</u> , 191 <u>5</u> , that I last saw her alive on <u>Jan 15</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>7.9</u> m. | | |
| 7 AGE <u>About 50</u> yrs. mos. ds. OR min. ? | If LESS than 1 day, hrs. | | The CAUSE OF DEATH* was as follows: <u>Acute, Epist. Intestinal Catarrh & Chol. cytolitis</u> | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Cook</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Private Home</u> | | | Contributory (Duration) yrs. mos. ds. <u>Auto-toxaemia</u> Secondary | | |
| 9 BIRTHPLACE (State or country) <u>Virginia</u> | | | (Signed) <u>B. R. Banaon</u> , M. D. <u>Jan 15</u> , 191 <u>5</u> (Address) <u>Cockeysville Md</u> | | |
| PARENTS | 10 NAME OF FATHER <u>(unknown) White</u> | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u> | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence. | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | 19 PLACE OF BURIAL OR REMOVAL <u>Stromsons Chapel</u> DATE OF BURIAL <u>Jan 14</u> , 191 <u>5</u> | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | 20 UNDERTAKER <u>Wm C Brooks</u> ADDRESS <u>Sparks Md</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. E. G. Werryman</u> (Address) <u>Cockeysville Md</u> | | | | | |
| 15 Filed <u>Jan 17</u> , 191 <u>5</u> <u>B. R. Banaon Jr M.D.</u> REGISTRAR <u>Deputy</u> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

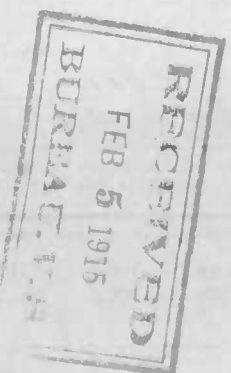
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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270

PLACE OF DEATH City Detention Hospital
for Insane

STATE OF MARYLAND
CERTIFICATE OF DEATH

County Baltimore

Registration Dist. No. 41

Village or City Bay View Asylum

(No. 56)

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Levey Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH January 11, 1880
(Month) (Day) (Year)

7 AGE 34 yrs. 0 mos. 0 ds. If LESS than 1 day, 0 hrs. OR 0 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ?
(b) General nature of industry, business, or establishment in which employed (or employer) ?

9 BIRTHPLACE (State or country) ?

PARENTS
10 NAME OF FATHER ?
11 BIRTHPLACE OF FATHER (State or country) ?
12 MAIDEN NAME OF MOTHER ?
13 BIRTHPLACE OF MOTHER (State or country) ?

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1420 Bruce Street

15 Filed Jan 13, 1915 Miriam Baul
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 12th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 11, 1915 to January 12th, 1915.

that I last saw him alive on January 12th, 1915.

and that death occurred on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Delirium Tremens

(Duration) 0 yrs. 0 mos. 0 ds.

Contributory Acute Dilatation of the heart
Secondary

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Philip Pearlstein M. D.
Jan 13, 1915 (Address) City Detention Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 23 hrs In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence 0 yrs. 0 mos. 0 ds.

19 PLACE OF BURIAL OR REMOVAL Mt. Auburn DATE OF BURIAL Jan - 18, 1915

20 UNDERTAKER Wm. J. Johnson ADDRESS 506 Baker St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accidental*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

271

County

Baltimore

(30)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

37

Village or City

Butler

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Hallie Marie Jordan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Infant

6 DATE OF BIRTH

May

6

1914

(Month)

(Day)

(Year)

7 AGE

7

28

If LESS than 1 day, hrs. OR min. ?

yrs.

mos.

ds.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore Md

PARENTS

10 NAME OF FATHER

Herbert B. Jordan

11 BIRTHPLACE OF FATHER (State or country)

Butler Md

12 MAIDEN NAME OF MOTHER

Cecilia Martin

13 BIRTHPLACE OF MOTHER (State or country)

Groh Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herbert B. Jordan

(Address)

Bockersville Md

15

Filed

Jan 1st

1915

J. H. Drach Md

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan

1st

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec 19th

1914, to

Jan 1st

1915

that I last saw her alive on Jan 1st, 1915

and that death occurred on the date stated above, at 4:15 A. M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) yrs. mos. 12 ds.

Contributory Secondary

Convulsions

(Duration) yrs. mos. 13 ds.

(Signed)

J. H. Drach

M. D.

Jan 1st, 1915 (Address) Bockersville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

yrs. mos. ds.

In the State

yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Black Rock Cemetery

Jan 3, 1915

20 UNDERTAKER

ADDRESS

Wm. C. Borak's

Sparks Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

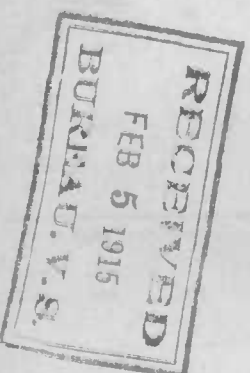
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1 PLACE OF DEATH

272

County

Baltimore

Village or City

Lesterville Spring Grove St.

(No.)

Registration Dist. No.

30

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Rebecca Katz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Jan 27th, 1884

7 AGE

37 yrs. 0 mos. 1 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Russia

10 NAME OF FATHER

Jacob Miller

11 BIRTHPLACE OF FATHER (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Lena Jacks

13 BIRTHPLACE OF MOTHER (State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Katz

(Address)

533 Asquith St.

15

Filed

Jan 29, 1915 Marshall Block

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

Jan 28th, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from May 22nd, 1912, to Jan 28th, 1915,that I last saw him alive on Jan 28th, 1915,

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Percy Wade, M. D.

Jan 29th, 1915 (Address) Calverville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 2 yrs. 8 mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

Dulles, Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hobbs Workmen circle

1/29, 1915

20 UNDERTAKER

on 6 Carmel Rd

Jack Lewis

1414 E. Balto St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—(oil mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.* *Carcin-*

oma. Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 da.*; *Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tumult," "Marasmus," "Old Age," "Shock," "Traculia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

273

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

32

Village or City

Mt Hope Retreat - Mt Hope Md

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Michael Keegan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Not Known

(Month)

(Day)

(Year)

7 AGE

abt 48

yrs.

mos.

ds.

 1 LESS than
t day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Bailer Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

Machinery etc

9 BIRTHPLACE

(State or country)

Ireland

PARENTS

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER (State or country)

Supposed to be Ireland

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (State or country)

Ireland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Records of Mt Hope Retreat

(Address)

Mt Hope Retreat - Mt Hope Md.

15

Filed

Jan 4, 1915 Wm. J. Owen

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 3rd, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 4th 1899, to Jan 3rd, 1914

that I last saw him alive on Jan 2nd, 1914

and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Melancholia - Chronic (Myocardia)

abt 15 or 16 yrs (Duration) yrs. mos. ds.

Contributory Secondary

Heart - Enlarged

Cardiac Collapse (Duration) abt 1 yrs. 1 mos. 0 ds.

(Signed) Frank J. Flannery, M. D.

Jan 3rd, 1914 (Address) Mt Hope Retreat

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place abt 23 yrs In the State

Where was disease contracted, Baltimore Md.

Former or usual residence Baltimore Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

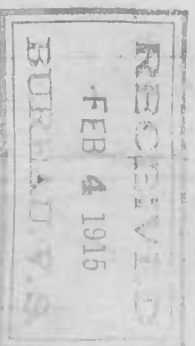
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faithfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

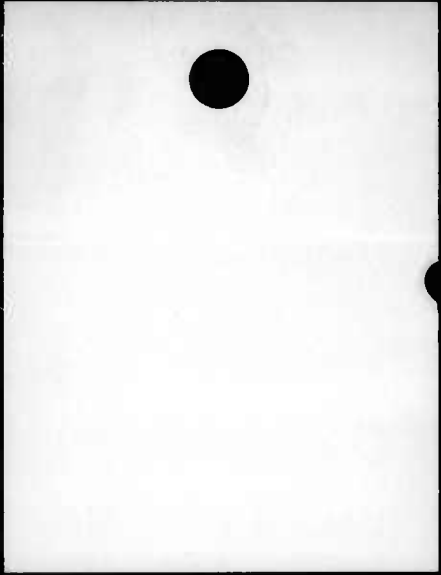
Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital" "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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Year?



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH 274
County Balt -

Village or City Boring (No. 113)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 24

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Anna Rosina Kehrberger

PERSONAL AND STATISTICAL PARTICULARS

³ SEX female ⁴ COLOR OR RACE white ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

⁶ DATE OF BIRTH 7 5, 1828
(Month) (Day) (Year)

⁷ AGE 66 yrs 6 mos. ds. OR min.?
It LESS than 1 day, hrs.

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Germany

¹⁰ NAME OF FATHER Lenhard Keisel

¹¹ BIRTHPLACE OF FATHER (State or country) Germany

¹² MAIDEN NAME OF MOTHER Unknown

¹³ BIRTHPLACE OF MOTHER (State or country) Unknown

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Bosley

(Address) Boring Md

¹⁵ Filed Jan 5, 1915 Cyril Chas Froelich
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH 1 5, 1915
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from Jan, 1914 to Jan 22, 1915,
that I last saw her alive on Jan 22, 1915

and that death occurred on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

carcinosis of the Liver

(Duration) 2 yrs. mos. ds.

Contributory
Secondary

(Duration) yr. mos. ds.

(Signed) Just Wilson, M. D.
(Address) Loroblesburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yr. mos. ds. In the State yr. mos. ds.

Where was disease contracted, if not at place of death?
Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL St. Paul Cemetery DATE OF BURIAL Jan 7, 1915
²⁰ UNDERTAKER Chas. Lipton & Son ADDRESS Hampstead

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

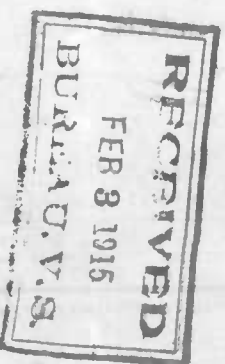
Approved by U. S. Census and American Public Health Association.¹

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STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Balto

(92)

Registration Dist. No. 41Village or City Highlandtown (No. 501 S 16th St) St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Arlene E. M. Kelly

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH Sept 28, 1914
(Month) (Day) (Year)7 AGE 3 yrs. 4 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Balto Co10 NAME OF FATHER Wm H Kelly11 BIRTHPLACE OF FATHER (State or country) Ind12 MAIDEN NAME OF MOTHER Florence Schneider13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Wm Schneider(Address) 501 S 16th St15 Filed Jan 2, 1915 W. E. McQuinn

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 2, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Dec. 30, 1914 to Jan 12, 1915

that I last saw him alive on _____, 191____

and that death occurred on the date stated above, at 9:10 P. M.

The CAUSE OF DEATH was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory Exhaustion

(Duration) yrs. mos. ds.

(Signed) Wm H Kelly M. D.Jan 2, 1915 (Address) 501 S 16th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oak LawnDATE OF BURIAL Jan 3, 191520 UNDERTAKER W. E. McQuinnADDRESS 1208 E. St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

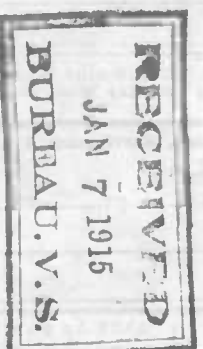
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County BaltimoreVillage or City Bay View Asylum(No. 91)

CITY HOSPITAL

Registration Dist. No. 41St.; Ward

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Laura Kessler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Unknown
(Write the word)

6 DATE OF BIRTH 1.845
(Month) (Day) (Year)

7 AGE 70 yrs. 0 mos. 0 ds. 0 OR 1 LESS than 1 day, 0 hrs. 0 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James Glanville

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Dobb

13 BIRTHPLACE OF MOTHER (State or country) Glatville

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaac Glanville(Address) 523 Wesley St.

15 Filed Jan 24, 1915 William Bair
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH January 23rd, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from November 1st 1915 to January 23rd, 1915.

that I last saw her alive on January 23rd, 1915

and that death occurred on the date stated above, at 10.10 p.m.

The CAUSE OF DEATH* was as follows:

Bronch Senility
(Duration) Unknown yrs. 0 mos. 0 ds.

Contributory Bronchopneumonia
Secondary Unknown yrs. 0 mos. 2 ds.

(Signed) U. C. Pinckney, M. D.

Jan. 24th 1915. (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 0 mos. 22 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence W. Pratt St.

19 PLACE OF BURIAL OR REMOVAL Loudon Park DATE OF BURIAL Jan 25, 1915

20 UNDERTAKER Jos. B. Cook ADDRESS 1003 W. Balto.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 277

County Balto

(64)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 36Village or City: Md Line (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Daniel Koller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married
(Write the word)6 DATE OF BIRTH Oct. 14, 1842
(Month) (Day) (Year)7 AGE 72 yrs. 3 mos. 11 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 3 yrs.9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Daniel Koller11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER Mary E. Koller13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Geo Hunk(Address) Parkton Balto Co15 Filed Jan 25, 1915 CHZ/KYS/ML

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 25, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY That I attended deceased from Jan. 23, 1915, to Jan. 25, 1915, that I last saw him alive on Jan 24, 1915and that death occurred on the date stated above, at 4:30 a. m.
The CAUSE OF DEATH* was as follows:Cerebral Hemorrhage
(Duration) ____ yrs. ____ mos. 3 ds.

Contributory (Secondary)

(Signed) M. C. Mummich, M. D.
Jan 25, 1915 (Address) Shrewsbury Pa.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. to the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Catholic Cemetery DATE OF BURIAL Jan 28, 1915
Shrewsbury Pa.20 UNDERTAKER Hartenstein Home Makers ADDRESS Bentley Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECORDED
FEB 3 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Baltimore

278

157

Village or City

Catonsville

(No.

St.

Ward)

Registration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Annie Krause

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Jan 25, 1915

(Month)

(Day)

(Year)

7 AGE

If LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Catonsville Md

PARENTS

10 NAME OF FATHER

John R Krause

11 BIRTHPLACE OF FATHER

(State or country)

Howard Co

12 MAIDEN NAME OF MOTHER

Annie Kristner

13 BIRTHPLACE OF MOTHER

(State or country)

Anne Arundel Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John R Krause

(Address)

Catonsville Md

15

Filed

Jan 27, 1915 Marshall B Wrist

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 26, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 25, 1915, to Jan 26, 1915,

that I last saw him alive on Jan 26, 1915,

and that death occurred on the date stated above, at 8 P m,

The CAUSE OF DEATH* was as follows:

Premature Birth
about 7 months

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Marshall B Wrist, M. D.

Jan 27, 1915 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

On Premises

Jan 28, 1915

20 UNDERTAKER

ADDRESS

John R Krause

Catonsville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

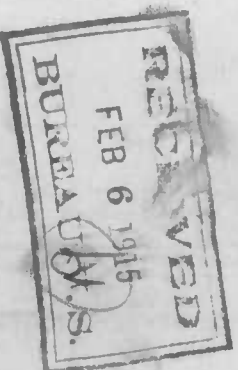
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recoiler wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Balto

Village or City

Canton

(No.)

(St.)

Ward)

2 FULL NAME

John Krauss

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41-

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Widowed

6 DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7 AGE

about 45 yrs.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

John Krauss

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nicholas Wolf

(Address)

3823 Foster Ave

15

Filed

Jan. 17, 1915

W. E. M. Clavahan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 17, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h. alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Struck by freight train
accidental

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

A. S. Warner, M. D.

Jan. 17, 1915 (Address) Coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

3334 Jefferson St Jan 17, 1915

20 UNDERTAKER

ADDRESS

Christian Miller 2834 Jefferson St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

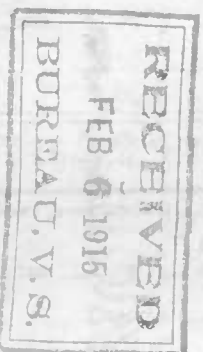
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| | | | | | |
|---|---------------------------------|--|--|---|--|
| 1 PLACE OF DEATH County <u>Balto</u> | | 280 (79) | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Chatnut Ridge Md</u> | | St.; Ward | | Registration Dist. No. <u>37</u> | |
| 2 FULL NAME <u>Friedrich Krempel</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u> | | | |
| 6 DATE OF BIRTH <u>Dec 21</u> , 18 <u>91</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>73</u> yrs. <u>1</u> mos. <u>4</u> ds. If LESS than 1 day,.....hrs. OR.....min.? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Germany</u> | | | | | |
| PARENTS | | | | | |
| 10 NAME OF FATHER <u>Friedrich Krempel</u> | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> | | | | | |
| 12 MAIDEN NAME OF MOTHER <u>Sophia Andrew</u> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Margaret Krempel</u> (Address) <u>Glyndon Md</u> | | | | | |
| 15 Filed <u>Jan 27</u> , 19 <u>15</u> . <u>B. F. Busey</u> M D REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>Jan 26</u> , 19 <u>15</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 16</u> , 19 <u>15</u> , to <u>Jan 26</u> , 19 <u>15</u> , that I last saw him alive on <u>Jan 26</u> , 19 <u>15</u> , and that death occurred on the date stated above, at <u>2 P.</u> m. | | | | | |
| The CAUSE OF DEATH* was as follows: <u>Myocardial Infarction</u> <u>Dilated Heart / Dropsy</u> <u>Ordinary of Lung</u> (Duration) <u>1</u> yrs. <u>1</u> mos. <u>4</u> ds. Contributory <u>Dilatation of Heart + Coronaries</u> Secondary <u>Asthma</u> (Duration) <u>2</u> yrs. <u>1</u> mos. <u>4</u> ds. (Signed) <u>B. F. Busey</u> , M. D. <u>Jan 27</u> , 19 <u>15</u> . (Address) <u>Texas Md</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>1</u> yrs. <u>1</u> mos. <u>4</u> ds. In the State <u>1</u> yrs. <u>1</u> mos. <u>4</u> ds. Where was disease contracted, if not at place of death? Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Druid Ridge Cemetery</u> DATE OF BURIAL <u>Jan 28</u> , 19 <u>15</u> | | | | | |
| 20 UNDERTAKER <u>J. F. Eline</u> ADDRESS <u>Reisterstown Md</u> | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

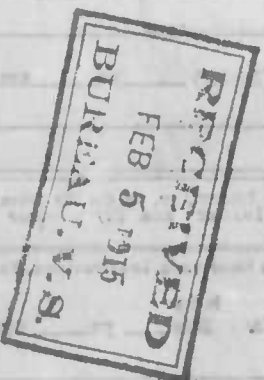
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculous of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scoble," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

281

County Baltimore

28

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Bay View Asylum(No. 1)St. 13 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Wiles Kudzier

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)single

6 DATE OF BIRTH

1895
(Month) (Day) (Year)

7 AGE

20

yrs.

mos.

ds.

It LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of workSalesman in copper mill(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)Russia

PARENTS

10 NAME OF
FATHERUnknown11 BIRTHPLACE
OF FATHER
(State or country)"12 MAIDEN NAME
OF MOTHER"13 BIRTHPLACE
OF MOTHER
(State or country)"

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records
Bay View

(Address)

15

Filed

Jan 3, 1915Miriam Bauer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 2, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov 13, 1914 to Jan 2, 1914that I last saw him alive on Jan 2, 1914and that death occurred on the date stated above, at 9.05 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis(Duration) Unknown ds.Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) F. J. Callahan, M. D.Jan 2, 1914 (Address) City St Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the ____ State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death? UnknownFormer or usual residence 3015 Fair Ave

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balto. 1st Evangelical Jan 5th, 1915

20 UNDERTAKER

ADDRESS

Christian Miller Montford Ave +If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. Jefferson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JAN 5 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | |
|---|---|---|---|---|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 282 (120) | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Highlandtown</u> (No. <u>3209 Foster Ave.</u> St.; _____ Ward) | | Registration Dist. No. <u>41</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |
| 2 FULL NAME <u>Sarah J. Krupp</u> | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married.</u> | | |
| 6 DATE OF BIRTH <u>Dec. 21</u> , 18 <u>88</u> (Month) (Day) (Year) | | | | |
| 7 AGE <u>66</u> yrs. <u>19</u> mos. <u>19</u> ds. | | If LESS than 1 day, ____ hrs. ____ min. ? | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>At Home</u> | | | | |
| 9 BIRTHPLACE (State or country) <u>Baltimore Co. Md.</u> | | | | |
| PARENTS | 10 NAME OF FATHER <u>George Buckingham</u> | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u> | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Edward L. Krupp</u> (Address) <u>3209 Foster Ave</u> | | | | |
| 15 Filed <u>Jan 13</u> , 19 <u>15</u> <u>H. W. E. McClanahan</u> REGISTRAR <u>M. J. Tilly & Ziehl</u> | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| 16 DATE OF DEATH <u>Jan. 9</u> , 19 <u>15</u> (Month) (Day) (Year) | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>12/27/14</u> , 19 <u>14</u> , to <u>1/9/15</u> , 19 <u>15</u> , that I last saw her alive on <u>1/9/15</u> , 19 <u>15</u> , and that death occurred on the date stated above, at <u>7:55</u> p.m. The CAUSE OF DEATH* was as follows: <u>Myocarditis Chronica</u> (Duration) <u>2</u> yrs. ____ mos. ____ ds. Contributory <u>Interstitial Nephritis</u> Secondary (Duration) <u>3</u> yrs. ____ mos. ____ ds. (Signed) <u>H. W. E. McClanahan</u> , M. D. <u>1/11/15</u> , 19 <u>15</u> (Address) <u>2919 E. Balto. St.</u> | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____ | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Cook's Lane Cem.</u> DATE OF BURIAL <u>Jan 13, 1915</u> ADDRESS <u>403 B. Wolfe</u> | | | | |
| 20 UNDERTAKER <u>M. J. Tilly & Ziehl</u> | | | | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

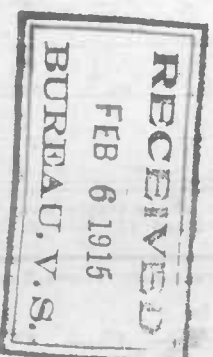
Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic) "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scule," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Baltimore

283

(No.

Village or City

Hullsville

St.;

Ward)

Registration Dist. No.

1421

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Kyler Muscorino 2 mo

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

unknown

4 COLOR OR RACE

cold

5 SINGLE,
MARRIED,
WIDDED,
ORDIVIDCED
(Write the word)

6 DATE OF BIRTH

1 21, 1913
(Month) (Day) (Year)

7 AGE

Muscorino

If LESS than
1 day, hrs.
yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Hullsville Baltimore

PARENTS

10 NAME OF FATHER

Joseph W. Kyler

11 BIRTHPLACE OF FATHER (State or country)

Md

12 MAIDEN NAME OF MOTHER

Esther Grace

13 BIRTHPLACE OF MOTHER (State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

ZB Hall

(Address)

Mt Vernon

15

Filed Jan. 23, 1915

F H Ruhl

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

1 21, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 21, 1915, to Jan. 22, 1915,
that I last saw him alive on Dec. 21, 1915.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Miscorino

2 months

(Duration) yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

ZB Hall

, M. D.

Jan. 22, 1915 (Address) Mt Vernon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hullsville buried Jan. 23, 1915

20 UNDERTAKER

ADDRESS

Joseph Kyler the father Mt Vernon

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

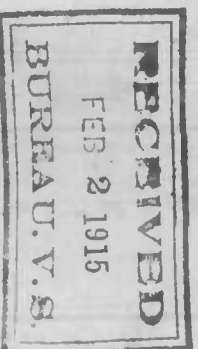
[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County BaltimoreVillage or City Baltimore

(No. _____)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James Labby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 1858

(Month) (Day) (Year)

7 AGE 57 yrs. 0 mos. 0 ds.If LESS than
1 day, _____ hrs.
OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Labby

11 BIRTHPLACE OF FATHER

(State or country) France12 MAIDEN NAME OF MOTHER E. Elizabeth White

13 BIRTHPLACE OF MOTHER

(State or country) W. S. A.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis B. Labby(Address) 17 Belair Rd

15

Filed Jan 7, 1915Miriam Bae

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 6, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1914, to Jan 6, 1914.that I last saw him alive on Jan 5, 1914.and that death occurred on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Pat. th. B. th. B.(Duration) _____ yrs. 7 mos. 7 ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F. J. Callahan, M. D.Jan. 6, 1914. (Address) City St. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. 1 mos. 13 ds. In the State 11 mos. _____ ds.Where was disease contracted, If not at place of death? V. M. M. M.Former or usual residence (no address) 17 Belair Rd

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery Dec 8th, 1915

20 UNDERTAKER

ADDRESS

H. B. Wiedefeld 914 Greenmount

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

ATE.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

285.

County

Baltimore

(7)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

Village or City

Highlandtown (No. 1) Sydenham Hospital Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Roy Labuff

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Unknown

6 DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7 AGE

Unknown

If LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

Lunch Room

9 BIRTHPLACE

(State or country)

Unknown

PARENTS

10 NAME OF FATHER

George Labuff

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Jan. 30th, 1915J. H. Hogan M.D.
deputy local REGISTRAR

16 DATE OF DEATH

January 30th, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY That I attended deceased from

Jan. 29th, 1915, to Jan. 30th, 1915.that I last saw him alive on Jan. 30th, 1915and that death occurred on the date stated above, at 12.25 a.m.

The CAUSE OF DEATH* was as follows:

Scarlet feverContributory
SecondaryPulmonary oedema
4 hours

(Signed)

J. H. Hogan, M. D.Jan. 30th, 1915 (Address) Sydenham Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 13 hours In the Unknown State Unknown yrs. mos. ds.Where was disease contracted, If not at place of death? UnknownFormer or usual residence Highlandtown, Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rochester, N. Y.191

20 UNDERTAKER

George M. Fink

ADDRESS

N. Wolfe St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

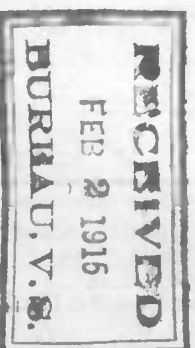
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore

286

(79)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Bay View Asylum(No. CITY HOSPITAL)St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Minerva Lantenklos

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 1.872
(Month) (Day) (Year)

7 AGE 43 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER William Lantenklos

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Josephine Forbes

13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15 Filed Jan 28, 1915 Miriam Baer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH January 28th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8th, 1914 to January 28th, 1915.

that I last saw her alive on January 28th, 1915and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
unknown
(Duration) yrs. mos. ds.

Contributory Valvular Stenosis
Secondary unknown
(Duration) yrs. mos. ds.

(Signed) U. C. Principe, M. D.Jan. 28th 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 4 mos. 20 ds. In the State yrs. mos. ds.

Where was disease contracted, unknown
If not at place of death?

Former or usual residence 203 N. Poppelton St. City.

19 PLACE OF BURIAL OR REMOVAL St. Peter's Church DATE OF BURIAL Jan 30, 1915

20 UNDERTAKER Harry W. Ehlert ADDRESS 1944 W. North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

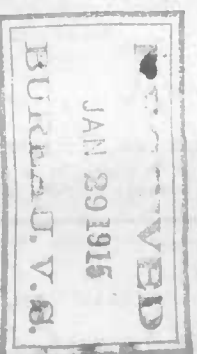
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theulia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | |
|---|---|--|----|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 287 | 28 | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Rustertown</u> (No., St.; Ward) | | Registration Dist. No. <u>33</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Rachael Lazarus</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>7</u> | 4 COLOR OR RACE <u>W</u> | 5 MARRIED, <u>Married</u> WIDOWED, OR DIVORCED (Write the word) | | | |
| 6 DATE OF BIRTH, 1862 (Month) (Day) (Year) | | | | | |
| 7 AGE <u>53</u> yrs. mos. ds. OR LESS than 1 day. hrs. min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Reddy</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Russia</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Unknown</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Glebo</u> (Address) <u>Jew. Cemetery Home</u> | | | | | |
| 15 Filed <u>July 16, 1915</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>January 16, 1915</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 12, 1915</u> , to <u>Jan 16, 1915</u> , that I last saw her alive on <u>Jan 16, 1915</u> , and that death occurred on the date stated above, at <u>7 A</u> m. The CAUSE OF DEATH* was as follows: <u>Diabetes</u> | | | | | |
| Contributory (Duration) <u>5</u> yrs. mos. ds. <u>Pulmonary Tuberculosis Stage II</u> Secondary (Duration) <u>3</u> yrs. mos. ds. | | | | | |
| (Signed) <u>Jack Lewis</u> , M. D. <u>Jan 16, 1915</u> (Address) <u>Jew. Cemetery Home</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. <u>4</u> ds. In the State <u>8</u> yrs. mos. ds. Where was disease contracted, <u>Baltimore City</u> If not at place of death? Former or usual residence <u>869 N. Exeter St. Balto. Md</u> | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Balton Hebrew Cemetery</u> | | | | DATE OF BURIAL <u>Jan 17, 1915</u> | |
| 20 UNDERTAKER <u>Jack Lewis</u> | | | | ADDRESS <u>1419 E. Balto. St.</u> | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

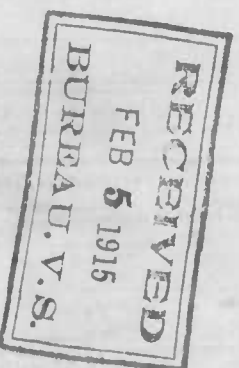
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

County

Baltimore

288

(92)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

43

Village or City

Raskeburg

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ernie Lee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

unknown

(Month)

(Day)

(Year)

7 AGE

80

yrs.

mos.

ds.

If LESS than 1 day, hrs. 1 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Cleaner Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

General Housework.

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur B. Gitch

(Address)

Raskeburg Md

15

Filed

Jan 17, 1915. W. F. Clayton

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 9th, 1915, to Jan 17th, 1915,that I last saw her alive on Jan 16th, 1915,and that death occurred on the date stated above, at 2:00 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration)

yrs.

mos.

ds.

Contributory
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

A. L. McKinnon

, M. D.

1-17-1915 (Address) Raskeburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gatch, Sandy CemeteryJan 18th, 1915

20 UNDERTAKER

ADDRESS

Fredrick LasswellFullerton Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Rereiber wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 4 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 289
 County Baltimore
 Village or City Highlandtown (No. 919 S. First St. St.; _____ Ward)
 2 FULL NAME George F. Leitner
 Registration Dist. No. 41
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH April 22, 1896
 (Month) (Day) (Year)

7 AGE 18 yrs. 9 mos. 8 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) General

9 BIRTHPLACE (State or country) Baltimore Co.

10 NAME OF FATHER Daniel Leitner

11 BIRTHPLACE OF FATHER (State or country) Balto Co.

12 MAIDEN NAME OF MOTHER Barbara Hensch

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Leitner

(Address) 919 S. First St.

15 Filed Feb 2, 1915 W. C. McQuadeau

REGIST 915

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 30, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1915, to Jan 30, 1915,
 that I last saw him alive on Jan 29, 1915.

and that death occurred on the date stated above, at 4:35 m.

The CAUSE OF DEATH* was as follows:

Laryngeal Phthisis

Contributory
 Secondary

(Signed) G. L. Blades, M. D.
Feb 2, 1915 (Address) 14376 19th May

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,
 If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St. Josephs Cem. Balto DATE OF BURIAL Feb. 2, 1915

20 UNDERTAKER Lilly & Co ADDRESS 403 S. May

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

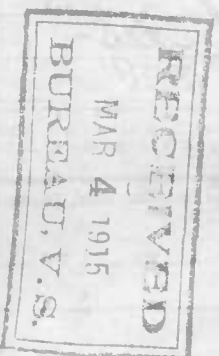
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH Balto 290
County Balto

Village or City Monkton (No. 61)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 39

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Eda Francis Lewis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH June 8, 1870
(Month) (Day) (Year)

7 AGE 39 yrs. 6 mos. 9 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Monkton Balto Md

10 NAME OF FATHER John Young

11 BIRTHPLACE OF FATHER (State or country) Monkton Balto Md

12 MAIDEN NAME OF MOTHER Carrie A. Standing

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Young
(Address) Monkton, Md.

15 Filed Jan. 18, 1915 Thos. H. Emory
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 17, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to Jan 16, 1915, that I last saw him alive on Jan 16, 1915

and that death occurred on the date stated above, at 11-30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral meningitis
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Signed) J. Ross Payne, M. D.
(Duration) yrs. mos. ds.
(Address) Corbett Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, AND RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Monkton Cemetery DATE OF BURIAL Jan. 19, 1915

20 UNDERTAKER John Brooks ADDRESS Deparks

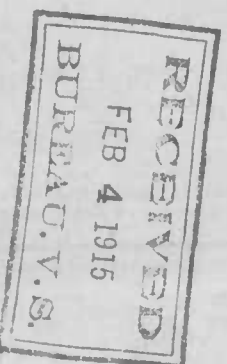
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH Baltimore 291
 County Baltimore (68)
 Village or City Catonsville (No. Spring Grove Rd. West St. Ward)
 Registration Dist. No. 30
 [It death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Julia Lieberman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)

6 DATE OF BIRTH Jan 10, 1862
 (Month) (Day) (Year)

7 AGE 53 yrs. 10 mos. 10 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Nurse
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Russia

PARENTS
 10 NAME OF FATHER Moses Dischler
 11 BIRTHPLACE OF FATHER (State or country) Russia
 12 MAIDEN NAME OF MOTHER Mark
 13 BIRTHPLACE OF MOTHER (State or country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julia Lieberman
 (Address) 2405 Druid Hill Ave

15 Filed Jan 10, 1915 Marshall B. West
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 10, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept-25, 1913, to Jan 10, 1915,
 that I last saw her alive on Jan 10, 1915

and that death occurred on the date stated above, at 4 P. m.
 The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) 2 yrs. 10 mos. 10 ds.
 Contributory (Secondary) Melancholia involuntaria

(Signed) Henry Wade, M. D.
Jan 10, 1915 (Address) Catonsville, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 3 mos. 15 ds. In the State 1 yrs. 10 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Balto. Md.

19 PLACE OF BURIAL OR REMOVAL Hebrew Washington DATE OF BURIAL Jan 11, 1915

20 UNDERTAKER Joak Lewis ADDRESS 1414 E Balto

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

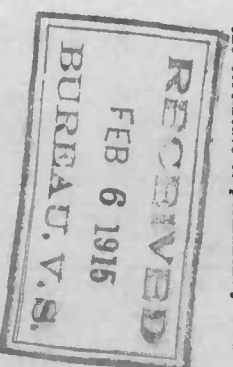
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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1 PLACE OF DEATH
County Baltimore

292

(10)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Catonsville (No. Johann Cake Rd St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jane B Gannon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow
(Write the word)

6 DATE OF BIRTH Unk Unk, 1898
(Month) (Day) (Year)

7 AGE 67 yrs. — mos. — ds. If LESS than 1 day, — hrs. — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Md

PARENTS
10 NAME OF FATHER Lwchas S Davis
11 BIRTHPLACE OF FATHER (State or country) Md
12 MAIDEN NAME OF MOTHER Unk
13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mears,

(Address) Woodlawn P O

15 Filed Jan 11, 1915 Marshall B Wist
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 10, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1914 to Jan 10, 1915.

that I last saw her alive on Jan 9, 1915.

and that death occurred on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

La Grippe,

(Duration) — yrs. — mos. 10 ds.

Contributory Cardiac asthma.
Secondary

(Duration) — yrs. — mos. 1 ds.

(Signed) Marshall B Wist, M. D.

Jan 10, 1915 (Address) Catonsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Greenmount Cemetery Jan 12, 1915

20 UNDERTAKER ADDRESS

E. A. Thiede 8. 2113 Greenmount

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

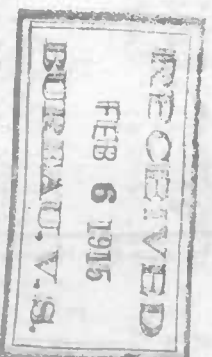
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theuia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

293

County

Balto

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Canton

(No.)

3506 Poore

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME (instead of street and number.)]

2 FULL NAME

Emma A. Lidard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

March 8, 1841

(Month)

(Day)

(Year)

7 AGE

73 yrs. 10 mos. 19 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.

none

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF
FATHER

Richard Mason

11 BIRTHPLACE
OF FATHER
(State or country)

England

12 MAIDEN NAME
OF MOTHER

Julia Morrison

13 BIRTHPLACE
OF MOTHER
(State or country)

W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James W. Lidard

(Address)

3506 Poore St

15

Filed

Jan 28, 1915 - W. E. McLaughlin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 27, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 1, 1915 to Jan. 27, 1915

that I last saw her alive on

Jan. 26, 1915

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(Duration) yrs. 8 mos. ds.

Contributory
Secondary

asthenia

(Duration) yrs. 1 mos. ds.

(Signed)

M. J. McLaughlin, M. D.

Jan 28, 1915 (Address) 839 S. E. Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Carmel

Jan 28, 1915

20 UNDERTAKER

ADDRESS

W. E. McLaughlin, 839 S. E. Street

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremula," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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294

1 PLACE OF DEATH

County BaltimoreVillage or City Bay View Asylum (No. 105) Bay View Asylum St. Ward STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Samuel Liggett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH , 1852
(Month) (Day) (Year)

7 AGE 63 yrs. mos. ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Peddler
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Virginia

PARENTS
10 NAME OF FATHER Unobtainable
11 BIRTHPLACE OF FATHER (State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records

(Address) Bay View

15 Filed Jan. 7, 1915 Miriam Bace
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 3rd, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11th, 1914, to Jan. 3rd, 1915.

that I last saw him alive on Jan. 3rd, 1915.

and that death occurred on the date stated above, at 6.45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Enteritis(Duration) 1 yrs. mos. ds.Contributory
Secondary(Duration) yrs. mos. ds.(Signed) M. C. Phillips, M. D.

Jan. 4th, 1915. (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 25 mos. 28 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? unknown

Former or usual residence Bay View Asylum

19 PLACE OF BURIAL OR REMOVAL Johns Hopkins Hosp DATE OF BURIAL Jan 7, 1915

20 UNDERTAKER G. L. Hurley ADDRESS 1109 7th St

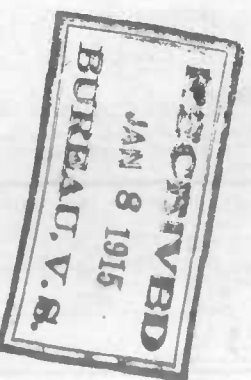
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore, Md.Village or City St. Agnes' Hospital

2 FULL NAME

Miss Alice Limke

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

November 19, 1900
(Month) (Day) (Year)

7 AGE

14 yrs. 2 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Schoolgirl9 BIRTHPLACE
(State or country)Baltimore

PARENTS

10 NAME OF FATHER

Frederick Limke11 BIRTHPLACE OF FATHER
(State or country)Baltimore

12 MAIDEN NAME OF MOTHER

Katherine Becker13 BIRTHPLACE OF MOTHER
(State or country)Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Fred Limke(Address) 3024 Stafford St.

15

Filed Jan 2, 1915 Henry H. Loos

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 79St. 79 Ward 79

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

Jan. 2, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1914 to Jan. 2, 1915that I last saw her alive on Jan. 2, 1915and that death occurred on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency(Duration) 1 yrs. 0 mos. 0 ds.Contributory
SecondaryCutaneous Pyemia(Duration) 19 yrs. 7 mos. 0 ds.(Signed) Harriet B. White, M. D.
Jan 2, 1915 (Address) St. Agnes' Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 3024 Stafford St.

19 PLACE OF BURIAL OR REMOVAL

Landon Park

DATE OF BURIAL

Jan 2, 1915

20 UNDERTAKER

Geo. Gerbig

ADDRESS

Balto & Payson St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

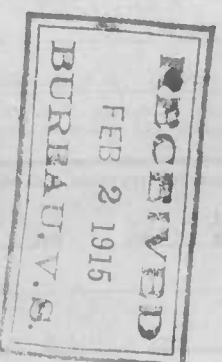
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH

296

County

Balto.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City

Mt. Vernon

(No.

St.

Ward)

2 FULL NAME

Harry E. Linton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6 DATE OF BIRTH

June

30

1881

(Month)

(Day)

(Year)

7 AGE

33

yrs.

11

mos.

29

ds.

If LESS than
1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Brickman

(b) General nature of industry, business, or establishment in which employed (or employer)

Steam Railroad.

9 BIRTHPLACE
(State or country)

Maryland.

10 NAME OF FATHER

Jno. A. Linton.

11 BIRTHPLACE OF FATHER
(State or country)

Maryland.

12 MAIDEN NAME OF MOTHER

Sarah. Dolphin.

13 BIRTHPLACE OF MOTHER
(State or country)

Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Gieton

(Address)

124 E. Barney St.

15

Filed

June

1915

L. H. Pugh

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June

1

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw h. alive on , 191,

and that death occurred on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows:

Crushed between two cars,
causing crushed abdominal
organs.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. Hall, coroner, 135 1/2 St. N. D.

June 1, 1915 (Address) Mt. Vernon, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross

June 4, 1915

20 UNDERTAKER

ADDRESS

E. B. Pugh

115 E. Kent St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

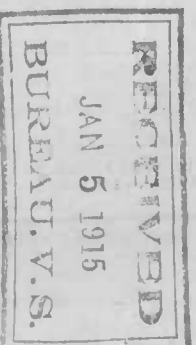
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*.

Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Tæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | | |
|---|---|---|--|---|--|
| 1 PLACE OF DEATH County <u>Balto</u> | | 297 <u>(S)</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Hightstown</u> (No. <u>3718</u> <u>Gough</u> St.; _____ Ward) | | Registration Dist. No. <u>41</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Abortion Jan. 7, 1915</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Not known</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | | | |
| 6 DATE OF BIRTH <u>Feb. 3, 1895</u> | | (Month) _____ (Day) _____ (Year) _____ | | | |
| 7 AGE <u>Abortion</u> | | If LESS than 1 day, _____ hrs. OR _____ min.? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>no</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>no</u> | | | | | |
| 9 BIRTHPLACE (State or country) <u>Balto Co Md</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Frederick Logan</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Cecil Co Md</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Louisa Hard</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Wentz N.J.</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Frederick Logan</u> (Address) <u>3718 Gough St.</u> | | | | | |
| 15 Filed <u>Feb 15, 1915</u> <u>W.E. McClanahan</u> REGISTRAR <u>md</u> | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>Jan. 7, 1915</u> (Month) _____ (Day) _____ (Year) _____ | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Abortion</u> to _____, 191____ that I last saw h_____ alive on _____, 191____ and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>took after birth of placenta</u> <u>Feb. 3, 15</u> (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| Contributory Secondary <u>abortion</u> (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>Jan L. O'Meara</u> M. D. <u>Feb 3, 1915</u> (Address) <u>248 So Third</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL | | | | DATE OF BURIAL _____, 191____ | |
| 20 UNDERTAKER | | | | ADDRESS | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

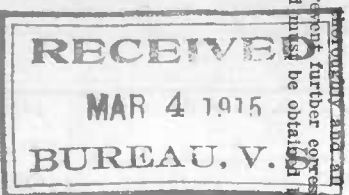
Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH

298

County Baltimore

(120)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 43Village or City Fullerton (No. Putty Hill Ave St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Antone Lucas

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH 6 25, 1888
(Month) (Day) (Year)

7 AGE 76 yrs. 6 mos. 9 ds. OR min. ?
It LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Europe

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Europe

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Europe

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. B. Allen
(Address) Fullerton Md

15 Filled Jan 5, 1915 W. B. Clayton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 5, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1914, to Jan 3, 1915.

that I last saw him alive on Jan 3, 1915.

and that death occurred on the date stated above, at 3:45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) yrs. mos. ds.

Contributory Cardiac Distention
Secondary

(Duration) yrs. mos. ds.

(Signed) W. B. Clayton, M. D.

Jan 5, 1915 (Address) Fullerton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore Cemetery DATE OF BURIAL Jan 5, 1915

20 UNDERTAKER Frederick L. Loeck ADDRESS Wm. B. Clayton

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

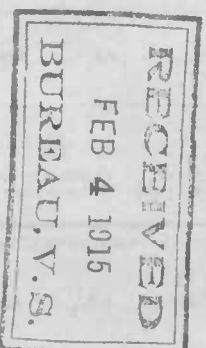
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1 PLACE OF DEATH 299 28
 County Baltimore
 Village or City Bay View Asylum (No. CITY HOSPITAL)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St.; _____ Ward)

2 FULL NAME Bennie Luter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH 1.880
 (Month) (Day) (Year)

7 AGE 35 yrs. 30 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?
 If LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Bennie Luter

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie Watts

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Hospital Records
 (Address) Bay View

15 Filed Jan 11, 1915 Miriam Baer
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 9th, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 7th, 1915 to January 9th, 1915.

that I last saw him alive on January 9th, 1915.

and that death occurred on the date stated above, at 9.30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
 (Duration) unknown yrs. 0 mos. 0 ds.

Contributory Tuberculous Enteritis
 Secondary (Duration) unknown yrs. 0 mos. 0 ds.

(Signed) W. C. Pinckney, M. D.
Jan. 11th 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. 2 ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?
 Former or usual residence 38 Hough St.

19 PLACE OF BURIAL OR REMOVAL Johns Hopkins Hosp. DATE OF BURIAL Jan 11, 1915

20 UNDERTAKER G. L. Hurley ADDRESS 1109 N. Helms

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

(1) ✓

SX.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

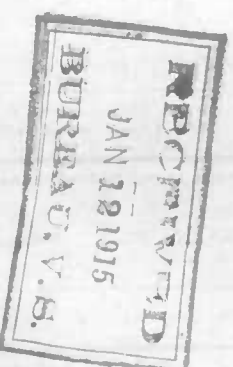
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| | | | | | |
|---|---------------------------------|---|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 300 (64) | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Gowans</u> (No. <u>572 Willow ave.</u> St. <u></u> Ward <u></u>) | | Registration Dist. No. <u>38</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Robert L. McCarriar</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u> | | 16 DATE OF DEATH <u>January 31</u> , 191 <u>5</u> (Month) (Day) (Year) | |
| 6 DATE OF BIRTH <u>Sept. 27</u> , 187 <u>0</u> (Month) (Day) (Year) | | 7 AGE <u>44</u> yrs. <u>4</u> mos. <u>4</u> ds. If LESS than 1 day, hrs. OR min. ? | | 17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 15</u> , 191 <u>4</u> , to <u>Jan 31</u> , 191 <u>5</u> , that I last saw him alive on <u>Jan 31</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>4-38 P. M.</u> The CAUSE OF DEATH* was as follows: <u>Cerebral Hemorrhage</u> (Duration) yrs. mos. ds. Contributory (Secondary) <u>Sclerosis of Arteries</u> (Duration) yrs. mos. ds. (Signed) <u>Francis D. McCarriar</u> , M. D. <u>Jan 31</u> , 191 <u>5</u> . (Address) <u>416 E North Ave</u> | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Sign Painter</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | 9 BIRTHPLACE (State or country) <u>Baltimore</u> | | 10 NAME OF FATHER <u>Geo McCarriar</u> | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore</u> | | 12 MAIDEN NAME OF MOTHER <u>Bertha F. Beach</u> | | 13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore</u> | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Thos B. McCarriar</u> (Address) <u>434 E. North Ave</u> | | | | | |
| 15 Filed <u>Feb 1st</u> , 191 <u>5</u> 17 | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence | | 19 PLACE OF BURIAL OR REMOVAL <u>London Park</u> DATE OF BURIAL <u>Feb 3</u> , 191 <u>5</u> | |
| 20 UNDERTAKER <u>Jickler & Jickler</u> | | ADDRESS <u>1739 E. Eager</u> | | | |
| 21 REGISTRAR <u>E. Eager</u> | | | | | |

① If more blanks are needed, address State Registrar, 6 E Franklin St., Balto. Requesting V. S. No. 1.

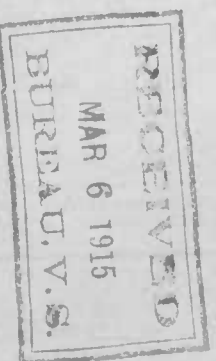
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be skated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

301

County BaltimoreVillage or City Bay View Asylum (No. CITY HOSPITAL) St.; WardSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Samuel L. McClain

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 1885
(Month) (Day) (Year)

7 AGE 29 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?
It LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Genl. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) Maryland

10 NAME OF FATHER John McClain

11 BIRTHPLACE OF FATHER
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15 Filed Jan 2, 1915 Marian Barr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 1st, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 17, 1914 to January 1st, 1915.

that I last saw him alive on January 1st, 1915.and that death occurred on the date stated above, at 10.45 A.M.

The CAUSE OF DEATH* was as follows:

Acute nephritis(Duration) yrs. 1 mos. 0 ds.Contributory Acute Endocarditis(Duration) yrs. unknown mos. 0 ds.(Signed) H. C. Pincoff, M. D.Jan. 2nd, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 1 mos. 17 ds. In the State yrs. 0 mos. 0 ds.Where was disease contracted, Baltimore
It not at place of death?Former or usual residence 829 Eastern Ave.

19 PLACE OF BURIAL OR REMOVAL Baltimore Cemetery DATE OF BURIAL Jan 3rd, 1915

20 UNDERTAKER Wm. Cook ADDRESS 502 E. North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | |
|--|--|---|---|---|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 302 | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Catonsville</u> (No. <u>68</u>) | | Registration Dist. No. <u>30</u> | | (If death occurred in a hospital or institution, give its NAME instead of street and number.) |
| 2 FULL NAME <u>Ella Rebecca M E Cullough</u> | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word) | | |
| 6 DATE OF BIRTH <u>Apr 8, 1869</u> (Month) (Day) (Year) | | | | |
| 7 AGE <u>45</u> yrs <u>9</u> mos <u>6</u> ds. If LESS than 1 day, hrs. OR min. ? | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | | |
| PARENTS | 10 NAME OF FATHER <u>Cornington B Gepp</u> | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Caroline Wall</u> | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>R Bradley Gepp</u> (Address) <u>Catonsville</u> | | | | |
| 15 Filed <u>Jan 15, 1915</u> <u>Marshall B West</u> REGISTRAR | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| 16 DATE OF DEATH <u>July 14, 1915</u> (Month) (Day) (Year) | | | | |
| 17 I HEREBY CERTIFY That I attended deceased from <u>June 13, 1915</u> , to <u>Jan 14, 1915</u> , that I last saw her alive on <u>Jan 14, 1915</u> , and that death occurred on the date stated above, at <u>8:30 p</u> m, The CAUSE OF DEATH* was as follows: | | | | |
| <u>Dementia Praecox</u> (Duration) <u>1</u> yrs <u>7</u> mos <u>1</u> ds. Contributory <u>Pernicious anaemia</u> Secondary (Duration) <u>3</u> yrs <u>3</u> mos <u>3</u> ds. (Signed) <u>J. Percy Wade</u> , M. D. <u>Jan 15, 1915</u> (Address) <u>Catonsville Md</u> | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>1</u> yrs <u>7</u> mos <u>1</u> ds. In the State <u>45</u> yrs <u>9</u> mos <u>6</u> ds. Where was disease contracted, <u>Howard County</u> If not at place of death? <u>near Clarksville</u> Former or usual residence <u>Clarksville Md</u> | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Linthicum Chapel bury</u> DATE OF BURIAL <u>July 17, 1915</u> | | | | |
| 20 UNDERTAKER <u>J. Hellminger</u> ADDRESS <u>Elliecot City</u> | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misadventure as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

303

County

Balto.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41-

Village or City

Highlandtown

(No.)

257 S. East Ave.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Francis McDaniel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6 DATE OF BIRTH

Sept. 23

(Month)

1835

(Day)

(Year)

7 AGE

79 yrs.

4 mos.

4 ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

house building

9 BIRTHPLACE

(State or country)

Maryland.

PARENTS

10 NAME OF FATHER

Harry McDaniel

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Mills

13 BIRTHPLACE OF MOTHER

(State or country)

not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robt. McDaniel

(Address)

3037 O'Donnell St.

15

Filed

Jan 30, 1915

W. E. McDaniel

REGISTERED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 27

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 16

1915, to

Jan 27

1915.

that I last saw him

alive on

Jan 27

1915.

and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

Contributory
Secondary

Chronic Intestinal Nephritis

(Duration)

3 yrs.

mos. 3 ds.

(Duration)

2 yrs.

mos. ds.

(Signed)

A. W. Wright

, M. D.

Jan 28

1915.

(Address)

2400 Ave. O'Donnell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Carmel Cemetery

Jan 30, 1915

20 UNDERTAKER

ADDRESS

Christina Miller

2334 Jefferson St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

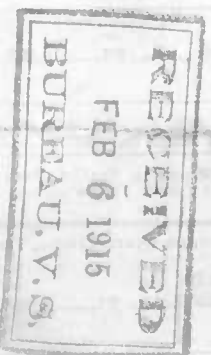
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-ferential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc., State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

304

County

Baltimore

Village or City

Mt Hope

(No.)

Mt Hope Retreat

St.

Ward)

Registration Dist. No.

32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Catherine McElroy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Don't Know

(Month)

(Day)

(Year)

7 AGE

abt

28

yrs.

0

mos.

0

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore Md

PARENTS

10 NAME OF FATHER

Hugh McElroy

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Catherine McGarry

13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Records of Mt Hope Retreat

(Address)

Mt Hope Md.

15

Filed

Jan 26, 1915 J. M. G. Owen

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan

25

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 31

1914

to Jan 25

1915

that I last saw her alive on Jan 24th, 1915

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Mania - Post Epilepsy -

Don't Know - (Duration) yrs. mos. ds.

Contributory
Secondary

Acute Enter - Colic

abt

(Duration)

yrs.

mos.

21 ds.

(Signed) Frank J. Flannery, M. D.

Jan 26th, 1915 (Address) Mt Hope Retreat

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

6

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, Baltimore (?)

If not at place of death? Former or usual residence Baltimore Md. (?)

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Catholic

Jan 29, 1915

20 UNDERTAKER

ADDRESS

Henry Hocke 1301 G. St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

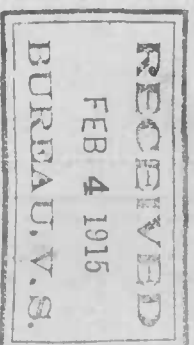
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 305

County Baltimore

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

Bay View Asylum

Village or City _____ (No. _____)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lothe Mc Ginn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH _____

(Month) (Day) (Year) 1. 1889

7 AGE

26 yrs. 0 mos. 0 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Germany

PARENTS

10 NAME OF FATHER

Andrew Leszka

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Zelski

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

1 Bay View

15

Filed Jan 23, 1915Marken Bau

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 22nd, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec. 12, 1914, to Jan. 22, 1915.

that I last saw her alive on Jan. 22, 1915and that death occurred on the date stated above, at 4.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulvis Pulmonis(Duration) 1 yrs. 7 mos. 0 ds.

Contributory

Tubercular enteritis

Secondary

(Duration) 1 yrs. 0 mos. 0 ds.(Signed) J. F. Callahan, M. D.Jan. 22, 1915. (Address) City St Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. 1 mos. 10 ds. In the State 1 yrs. 0 mos. 0 ds.Where was disease contracted, Unknown

If not at place of death? _____

Former or usual residence 933 Kenwood Ave.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Rosary Cemetery Jan 26, 1915

20 UNDERTAKER

ADDRESS

M. F. Sadowski 705 S. Ann

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congitital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County BaltimoreVillage or City Bay View (No. 28) St. WardSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Peter McGraw

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH

June 23, 1914
(Month) (Day) (Year)

7 AGE

60 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Gen'l Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

James McGraw

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Elizabeth Duffy

13 BIRTHPLACE OF MOTHER

(State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Bay View

15

Filed Jan 24, 1915Miriam Barr

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 17, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from June 23, 1914 to Jan 17, 1915that I last saw him alive on Jan 17, 1915and that death occurred on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia pneumoniae(Duration) 2 yrs. + mos. 0 ds.Contributory
Secondary(Duration) 0 yrs. 0 mos. 0 ds.(Signed) J. F. Callahan, M. D.Jan 17, 1915 (Address) City 36 Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 6 yrs. 25 mos. 25 ds. In the Unknown State Unknown yrs. 0 mos. 0 ds.Where was disease contracted, UnknownIf not at place of death? UnknownFormer or usual residence Frederick & Ayres Sts

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Jan 21, 1915

20 UNDERTAKER

ADDRESS

Henry Voelck & Son 1301 E. Eager

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 307
County Baltimore

Village or City Govanus (No. 28), Markland Ave St.; 38 Ward)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Margaret Marion McKenzie

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH March 24, 1889
(Month) (Day) (Year)

7 AGE 37 yrs. 9 mos. 22 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) New York State

10 NAME OF FATHER Sherman

11 BIRTHPLACE OF FATHER (State or country) Don't know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (State or country) New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Skell G. McKenzie

(Address) 7 Markland Ave

15 Filed Jan 3, 1915 Clara L. L...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 2, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June, 1914, to Jan 2, 1915, that I last saw him alive on Jan 2, 1915

and that death occurred on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 0 mos. 0 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) J. C. West MD, M. D.

Jan 2, 1915 (Address) Govanus Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death? 1

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Resurrection Cem DATE OF BURIAL Jan 5, 1915

20 UNDERTAKER Williams Cook ADDRESS Markland

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

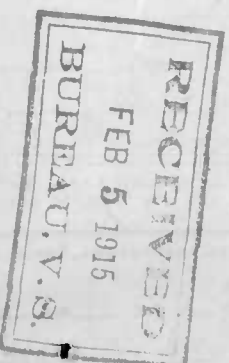
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Tropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | |
|---|--|---|---|---|
| 1 PLACE OF DEATH County <u>Balto Co</u> | | 308 | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Highlandtown</u> (No. <u>3307</u> <u>Budson</u>) | | Registration Dist. No. <u>41</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |
| 2 FULL NAME <u>Marie J. Magness</u> | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <u>female</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u> | | |
| 6 DATE OF BIRTH <u>May 17 1909</u> (Month) (Day) (Year) | | | | |
| 7 AGE <u>5</u> yrs. <u>7</u> mos. <u>28</u> ds. | | If LESS than 1 day, hrs. OR min. ? | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | |
| 9 BIRTHPLACE (State or country) <u>Balto Co</u> | | | | |
| PARENTS | 10 NAME OF FATHER <u>Barry L. Magness</u> | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Balto city</u> | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Augusta J. Bittner</u> | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Balto city</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>August J. Moore</u> (Address) <u>3307 Budson St.</u> | | | | |
| 15 Filed <u>Jan 14 1915</u> <u>W. E. M. Canahan</u> REGISTRAR | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| 16 DATE OF DEATH <u>Jan 14 1915</u> (Month) (Day) (Year) | | | | |
| 17 I HEREBY CERTIFY That I attended deceased from <u>Jan 13 1915</u> to <u>Jan 14 1915</u> that I last saw him alive on <u>Jan 13 1915</u> and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Scarlet fever</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory (Secondary) <u>uremia</u> (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>M. J. McAvoy</u> , M. D. <u>Jan 14 1915</u> (Address) <u>839 S. Ellwood St.</u> | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____ | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>St. Schwartz Cem</u> | | | | DATE OF BURIAL <u>Jan 15 1915</u> |
| 20 UNDERTAKER <u>Tom Loan</u> | | | | ADDRESS <u>Balto City</u> |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary). 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU, V. S.

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309

1 PLACE OF DEATH

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City Carney (No. Harford & Joppa Roads St., Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary P. Manser

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED single (Write the word)6 DATE OF BIRTH July 32, 1887
(Month) (Day) (Year)7 AGE 27 yrs. 6 mos. — ds. If LESS than 1 day, hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Maryland

| | | |
|---------|--|------------------|
| PARENTS | 10 NAME OF FATHER | <u>Not known</u> |
| | 11 BIRTHPLACE OF FATHER (State or country) | <u>Not known</u> |
| | 12 MAIDEN NAME OF MOTHER | <u>Not known</u> |
| | 13 BIRTHPLACE OF MOTHER (State or country) | <u>Not known</u> |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Fred Manser(Address) Harford & Joppa Roads15 Filed Jan 25, 1915 Claud Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 22, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1914, to Jan. 22, 1915.that I last saw him alive on Jan. 20, 1915and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis
Pulmonalis
S.U.B. (Duration) 8 yrs. — mos. — ds.Contributory
Secondary(Signed) A. C. Kearn M. D.
Jan. 24, 1915 (Address) 2600 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Trinity Cem DATE OF BURIAL Jan 26, 191520 UNDERTAKER Peter Nicolaus ADDRESS 2046 Eastern

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

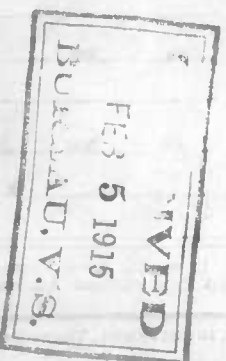
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

310

157

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. _____

Village or City Jacksonville (No. _____)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME not named

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Dec. 2, 1914
(Month) (Day) (Year)

7 AGE 0 yrs. 1 mos. 28 ds. It LESS than 1 day. _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Baltimore County

10 NAME OF FATHER Grover Marsh

11 BIRTHPLACE OF FATHER (State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Agnes Tillman

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John T. Tillman

(Address) Monkton R. D. #3, Md.

15 Filed Jan. 31, 1915 Thos. H. Emory
REGISTRAR

16 DATE OF DEATH Jan. 30, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw h _____ alive on _____, 191____.

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

not attended by any doctor,

Marasmus (Duration) since birth yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Signed) Thos. H. Emory, M. D.
Jan. 31, 1915 (Address) Monkton, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted?
It not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St. James P.E. Church, Manor, Baltimore Co. DATE OF BURIAL Feb. 1, 1915

20 UNDERTAKER John T. Tillman ADDRESS Monkton, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

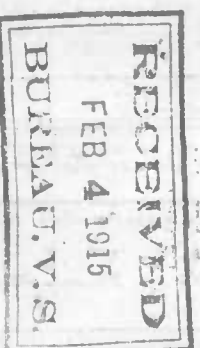
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

County

Baltimore Md.

311

167

Village or City

St. Agnes' Hospital

(No.)

St.

Ward)

Registration Dist. No.

425

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Myrtle Martin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

December 1, 1897

(Month)

(Day)

(Year)

7 AGE

17 yrs. 1 mos. 2 ds.

If LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Harford

PARENTS

10 NAME OF FATHER

Frank Martin

11 BIRTHPLACE OF FATHER (State or country)

Harford

12 MAIDEN NAME OF MOTHER

Annie Leiggin

13 BIRTHPLACE OF MOTHER (State or country)

Harford

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Frank Martin

(Address)

Harford Co. Md. Route # 2

15

Filed

Jan 10, 1915

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

Jan 9, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 9, 1915, to Jan 9, 1915, that I last saw her alive on Jan 9, 1915

and that death occurred on the date stated above, at 9:15 pm.

The CAUSE OF DEATH* was as follows:

Very Extensive 1st degree burn from clothes conflagration. Accidental Coal oil explosion

(Duration) yrs. mos. 1/3 ds.

Contributory
Secondary

(Duration) yrs. mos. 4 hrs.

(Signed)

E. A. Briston, M. D.

Jan 10, 1915 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence Harford Co. Md. Route # 2

19 PLACE OF BURIAL OR REMOVAL

Belair, Md.

DATE OF BURIAL

Jan 10, 1915

20 UNDERTAKER

J. E. Stough & Co.

ADDRESS

1422 Penna Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

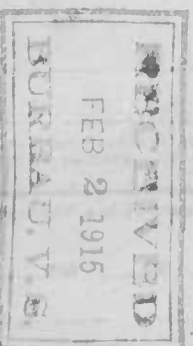
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The statement worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County BaltimoreVillage or City Bay View Asylum

312

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Josephine Martinek

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH 1. 8. 72
(Month) (Day) (Year)

7 AGE 43 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Cigar maker
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) New York

PARENTS
10 NAME OF FATHER Anton Belsky
11 BIRTHPLACE OF FATHER (State or country) Russia
12 MAIDEN NAME OF MOTHER Annie Fisher
13 BIRTHPLACE OF MOTHER (State or country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15 Filed Jan 2, 1915 Thurman Barr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 2, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1914 to January 2, 1915.

that I last saw her alive on Jan. 1st, 1915, and that death occurred on the date stated above, at 6.55 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Pulmonalis(Duration) 3 yrs. 0 mos. 0 ds.Contributory Influenza, enteritis + Paratyphoid(Duration) 1 yr. 0 mos. 0 ds.(Signed) F. J. Callahan, M. D.Jan 2, 1915. (Address) City & Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 8 mos. 0 ds. In the ? State ? yrs. ? mos. ? ds.Where was disease contracted, Unknown

If not at place of death?

Former or usual residence 919 N. Wolfe St

19 PLACE OF BURIAL OR REMOVAL Oak Hill Cemetery DATE OF BURIAL Jan 7th, 1915

20 UNDERTAKER Wm. Cook ADDRESS 502 E. North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mæsles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mæsles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Baltimore

313

79

Village or City Arlington

(No.

Narcissus Ave.

Ward)

Registration Dist. No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Edithe E. Masterton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white ~~SINGLE~~ ~~MARRIED~~ ~~WIDOWED~~ ~~ORPHANED~~ Married
(Write the word)

5 DATE OF BIRTH February 14, 1876
(Month) (Day) (Year)

7 AGE 41 yrs. 11 mos. 7 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm H Sheeler

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura Bright

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Masterton
Narcissus Ave Arlington
(Address)

15 Filed Jan 22, 1915 Wm. G. Queen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 21, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1915, to Jan 21, 1915

that I last saw h. alive on January 21, 1915

and that death occurred on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:
at Park Heights & Belvedere Ave
on January 21, 1915
from Heart Failure
(Duration) yrs. mos. ds.

Contributory (Secondary) None
(Duration) yrs. mos. ds.

(Signed) John Zimmerman, M. D.
1915 (Address) Arlington, Md

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Wood Ridge

20 UNDERTAKER William Cook

DATE OF BURIAL Jan 23, 1915

ADDRESS 507 E North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 4 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Baltimore Co.

314

(7)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highlandtown

(No.

3220-22 Eastern Ave

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Frederick W. Weisenhalder

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

April 14, 1910

7 AGE

4 yrs. 8 mos. 29 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

name

9 BIRTHPLACE

(State or country)

Baltimore Md

PARENTS

10 NAME OF FATHER

John V. Weisenhalder

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Amelia B. Bruttage

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Interment)

John V. Weisenhalder

(Address)

3730-22 Eastern Ave

15

Filed Jan. 13, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1/13, 1915

17

I HEREBY CERTIFY, That I attended deceased from

Dec 28, 1914, to Jan 13, 1915

that I last saw him alive on Jan 13, 1915

and that death occurred on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Scarletina

(Duration) yrs. mos. 17 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) A. Warner, M. D.

Jan 13, 1915 (Address) 3201 Highland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn

Jan 14, 1915

20 UNDERTAKER

ADDRESS

Sander & Sons

1710 F. Street

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecases*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecases* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anacmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 6 1915
BUREAU, V. S.

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| | | | | | | | | |
|--|--|-------------------------------------|----------------------------------|---|--|---|--|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | | 315 28 | | | STATE OF MARYLAND CERTIFICATE OF DEATH | | |
| Village or City <u>Baltimore</u> (No. <u>Balto. C.</u>) | | | Registration Dist. No. <u>33</u> | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | |
| 2 FULL NAME <u>Yetta Miller</u> | | | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | | |
| 3 SEX <u>7.</u> | | 4 COLOR OR RACE <u>W.</u> | | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word) | | | | |
| 6 DATE OF BIRTH <u>September</u> , 190 <u>3</u> (Month) (Day) (Year) | | | | | | | | |
| 7 AGE <u>13</u> yrs. <u>0</u> mos. <u>0</u> ds. | | | | If LESS than 1 day, hrs. OR min. ? | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>School child</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | | | | |
| 9 BIRTHPLACE (State or country) <u>Balto. Md.</u> | | | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Abraham Miller</u> | | | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Russia</u> | | | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | | | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Russia</u> | | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Herbert</u> (Address) <u>Baltimore Md</u> | | | | | | | | |
| 15 Filed <u>July 20</u> , 191 <u>5</u> <u>at residence</u> REGISTRAR | | | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | | |
| 16 DATE OF DEATH <u>January</u> <u>20</u> , 191 <u>5</u> (Month) (Day) (Year) | | | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>September 9</u> , 191 <u>4</u> , to <u>January 20</u> , 191 <u>5</u> , that I last saw <u>her</u> alive on <u>January 20</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>3:15 P. m.</u> The CAUSE OF DEATH* was as follows: <u>Pulmonary tuberculosis</u> | | | | | | | | |
| (Duration) <u>1</u> yrs. <u>4</u> mos. <u>0</u> ds. Contributory <u>Tuberculosis enter. colitis</u> Secondary | | | | | | | | |
| (Duration) <u>5</u> yrs. <u>0</u> mos. <u>0</u> ds. (Signed) <u>Janet Lecher</u> , M. D. <u>Jan. 20</u> , 191 <u>5</u> (Address) <u>Jeune's Consump. Home</u> | | | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>4</u> yrs. <u>11</u> mos. <u>11</u> ds. In the State <u>13</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, <u>Baltimore</u> if not at place of death? Former or usual residence <u>7515 E. Fayette St.</u> | | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Balto. Hebrew Cemetery</u> | | | | | | DATE OF BURIAL <u>Jan. 21</u> , 191 <u>5</u> | | |
| 20 UNDERTAKER <u>S. J. J. J.</u> | | | | | | ADDRESS <u>1107 E. Balto. St.</u> | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

1419 S. Balto. St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

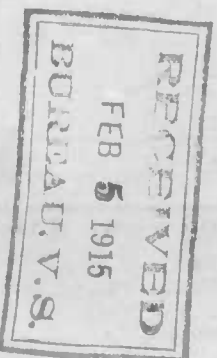
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

316

County Baltimore

(5)

Village or City Mt Washington (No. _____)Registration Dist. No. 32

St.; _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Unknown4 COLOR OR RACE White5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) —6 DATE OF BIRTH 1 8 1915

(Month) (Day) (Year)

7 AGE 4 yrs. 4 mos. — ds. OR — min. ?

If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work —(b) General nature of industry, business, or establishment in which employed (or employer) —9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER Freeman Miller11 BIRTHPLACE OF FATHER (State or country) Md12 MAIDEN NAME OF MOTHER Rachael Traylor13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. C. H. Beeton(Address) Mt. Washington

15

Filed Jan. 19 1915 Henry A. Taylor

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 8 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan - 8, 1915, to Jan 8, 1915,

that I last saw him alive on _____, 191_____

and that death occurred on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Abortion - Unknown -
may be due to large tear of cervix
causing weakness of uterus, history
negative (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Still - Birth)

(Signed) C. H. Beeton, M. D.Jan. 16, 1915 (Address) Mt Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thrown down closet _____, 191_____

20 UNDERTAKER

ADDRESS

F. Miller Mt. Washington

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmial," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 4 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

317

County

Batto

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

3 B

Village or City

near Boring (No. M d

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Gertude M. Milner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Jan 8, 1887
(Month) (Day) (Year)

7 AGE

28 yrs. — mos. 17 ds. OR — mln. ?
It LESS than 1 day. — hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Batto co Md

PARENTS

10 NAME OF FATHER

John Walter

11 BIRTHPLACE OF FATHER
(State or country)

Batto co Md

12 MAIDEN NAME OF MOTHER

Mary Sullivan

13 BIRTHPLACE OF MOTHER
(State or country)

Batto co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Milner

(Address)

Boring Batto co Md

15

Filed

July 26, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 25, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 15, 1914, to Jan 25, 1915.

that I last saw him alive on Jan 10, 1915.

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary & Laryngeal
Tuberculosis

(Duration) 1 yrs. 6 mos. ds.

Contributory
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) J. H. Eline, M. D.

July 26, 1915 (Address) Reesketown Md

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Paul Cemetery Jan 27, 1915

20 UNDERTAKER

ADDRESS

J. H. Eline Reesketown Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

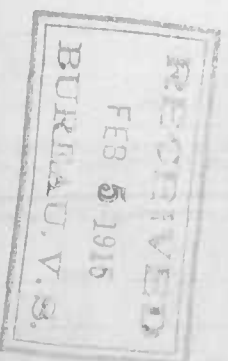
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

318

County

Baltimore

(5)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highlandtown

(No. 757 P. Fifth

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant of John & Theresa Mityg

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Jan. 25th, 1915
(Month) (Day) (Year)

7 AGE

6 1/2 mos. Pregnancy

If LESS than
1 day, hrs.
OR, min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE
(State or country)

Balto., County

PARENTS

10 NAME OF FATHER

John Mityg

11 BIRTHPLACE OF FATHER
(State or country)

Austria-Hungary

12 MAIDEN NAME OF MOTHER

Theresa Meyer

13 BIRTHPLACE OF MOTHER
(State or country)

Austria-Hungary

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Mityg

(Address)

257 S. 5th St.

15

Filed

Jan. 26, 1915 W.E.M. Clavahan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 25th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 25th, 1915, to Jan. 25th, 1915,
that I last saw her dead Jan. 25th, 1915

and that death occurred on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Still born
(Duration) yrs. mos. ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) M. Kahn, M. D.

Jan. 26th, 1915 (Address) 677 Columbia St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred Heart Cem. Jan. 27, 1915

20 UNDERTAKER

ADDRESS

Tilly & John 403 S. Wolfert

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County BaltimoreVillage or City Bay View Asylum.(No. CITY HOSPITAL)Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charles Mogerman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 1865
(Month) (Day) (Year)

7 AGE 50 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Mattress maker
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Russia

10 NAME OF FATHER John Mogerman

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER Yetta Mogerman

13 BIRTHPLACE OF MOTHER (State or country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address) Bay View

15 Filed Jan 23, 1915 Mrs. Sam Baer
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 22nd, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 18, 1914 to January 22nd 1915.

that I last saw him alive on January 22nd, 1915.

and that death occurred on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis
Duration unknown yrs. 0 mos. 0 ds.

Contributory Cerebral Thrombosis
Secondary Duration 1/2 yrs. 0 mos. 0 ds.

(Signed) H. C. Purciffe, M. D.
Jan. 23rd, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, unknown

If not at place of death? 25 N. Central Ave.

19 PLACE OF BURIAL OR REMOVAL Hebrew Cemetery DATE OF BURIAL Jan 24, 1915

20 UNDERTAKER Jack Lewis ADDRESS 419 E. Balt

at.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—guiltless*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

320

County BaltimoreVillage or City Bay View Asylum(No. 1)

CITY HOSPITAL

Registration Dist. No. 41St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Fred Moles (Moa)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 1. 832
(Month) (Day) (Year)

7 AGE 83 yrs. 0 mos. 0 ds. 0 OR 1 LESS than 1 day, 0 hrs. 0 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Fred Moles
11 BIRTHPLACE OF FATHER (State or country) South Carolina
12 MAIDEN NAME OF MOTHER Henretta Distance
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence Johnson(Address) 572 Oxford St.

15 Filed Jan 11, 1915 Miriam Baer
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 10th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 9th, 1915, to January 10th, 1915.

that I last saw him alive on January 10th, 1915

and that death occurred on the date stated above, at 12.45 P.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. 3 mos. 0 ds.

Contributory
Secondary

Senility

unknown

(Duration) yrs. 0 mos. 0 ds.

(Signed)

H. C. P. M. D.

Jan. 11, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 1 mos. 0 ds. In the State yrs. 0 mos. 0 ds.

Where was disease contracted,
If not at place of death?

Former or usual residence Bayview Asylum

19 PLACE OF BURIAL OR REMOVAL Laurel Cemetery DATE OF BURIAL Jan 10, 1915

20 UNDERTAKER Saml. T. Kennedy ADDRESS 578 N. Biddle

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

5X

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

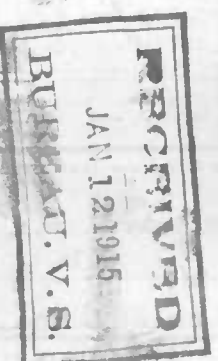
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

321

County Baltimore

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Ten Hills (No. Edmondson Ave St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Raymond Augustine Molloy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH August 28, 1885
(Month) (Day) (Year)

7 AGE 29 yrs. 4 mos. 9 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore, Md.

PARENTS
10 NAME OF FATHER James M. Molloy
11 BIRTHPLACE OF FATHER (State or country) Baltimore, Md.
12 MAIDEN NAME OF MOTHER Mary J. Sheehan
13 BIRTHPLACE OF MOTHER (State or country) Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos F. Molloy(Address) Ten Hills Balto Co, Md

15 Filed Jan 9, 1915 Marshall B. Woot
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 7, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1914, to Jan 7, 1915.

that I last saw him alive on Jan 7, 1915.

and that death occurred on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculum Pneumonia

(Duration) 3 yrs. 3 mos. 3 ds.
Contributory Laryngeal Tuberculosis
Secondary

(Signed) M. A. Neill, M. D.
Jan 8, 1915 (Address) 108 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Cathedral Cemetery DATE OF BURIAL Jan. 11, 1915

20 UNDERTAKER Henry W. Means ADDRESS 805 N. Calvert St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

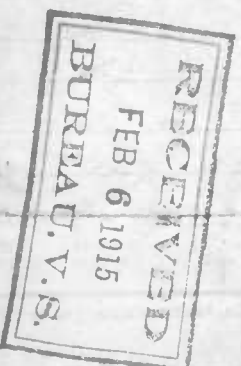
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Confining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Scuffle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County BaltoVillage or City Hightlandtown (No. 3410 E Lombard)

2 FULL NAME

Frederick MorgerethSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH June 29, 1862
(Month) (Day) (Year)

7 AGE 53 yrs. 6 mos. 7 ds. 1 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Shoe maker
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto

PARENTS
10 NAME OF FATHER Henry B Morgereth
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER Katharina Flettermuch
13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maggie Morgereth(Address) 3410 E Lombard

15 Filed Jan. 7 - 1914 W. E. M. Canavan

REGISTERED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 5th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to Jan 5th, 1914, that I last saw him alive on Jan 5th, 1914,

and that death occurred on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Acute dilatation of heart
(Duration) yrs. 2 mos. 2 ds.

Contributory Chronic bronchitis
Secondary (Duration) yrs. 6 mos. 6 ds.

(Signed) J. W. Schuler, M.D.
Jan 6, 1914 (Address) 330 E. Smith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Holy Redeemer Church DATE OF BURIAL Jan 8, 1914

20 UNDERTAKER Derwig & Co ADDRESS 2008 Adams

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

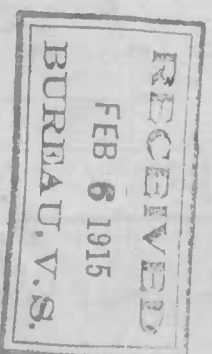
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accidental*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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323

1 PLACE OF DEATH

County BaltimoreVillage or City Bay View Asylum.(No. CITY HOSPITAL)Registration Dist. No. 41St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Timothy Morrison

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 1844
(Month) (Day) (Year)

7 AGE 71 yrs. 71 mos. 71 ds. OR 1 day, 1 hrs. 1 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ireland

PARENTS
10 NAME OF FATHER Patrick Morrison
11 BIRTHPLACE OF FATHER (State or country) Ireland
12 MAIDEN NAME OF MOTHER Bridget Longs
13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15 Filed Jan 23d 1915 Miriam Baer
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 30th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 29th 1915 to January 30th 1915.

that I last saw him alive on January 30th 1915.

and that death occurred on the date stated above, at 12.30 Pm.

The CAUSE OF DEATH* was as follows:

Chronic myocarditisUnknown(Duration) Unknown yrs. Unknown mos. Unknown ds.

Contributory Emphysema
Secondary Unknown

(Duration) Unknown yrs. Unknown mos. Unknown ds.(Signed) H. C. Pinckney, M. D.

Jan. 30, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted,
If not at place of death?

Former or usual residence 1116 William St.

19 PLACE OF BURIAL OR REMOVAL Holy Cross Cemetery DATE OF BURIAL Feb 2nd 1915

20 UNDERTAKER Wm. Cook ADDRESS 502 E. North Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 3 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

324

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City

Frederick Road & York Heights

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Frederick Mueller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

May 8, 1886
(Month) (Day) (Year)

7 AGE

53 yrs. 8 mos. 14 ds. If LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work. Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Ceph.

9 BIRTHPLACE (State or country)

Baltimore City

PARENTS

10 NAME OF FATHER

Frederick Mueller

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Louise Weber

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie Weber

(Address)

Athol Heights

15

Filed

Jan 24, 1915 Marshall B. [unclear]

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 22, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 22, 1915 to Jan 22, 1915

that I last saw him alive on Jan 22, 1915

and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis of Heart.

5 minutes (Duration) yrs. mos. ds.

Contributory Secondary

Acute Indigestion

(Signed)

J. B. Wilson, M. D.

Jan 23, 1915 (Address) 1735 Holla St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

Jan 25, 1915

20 UNDERTAKER

ADDRESS

ARMSTRONG-DENNY CO.

715 Light St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

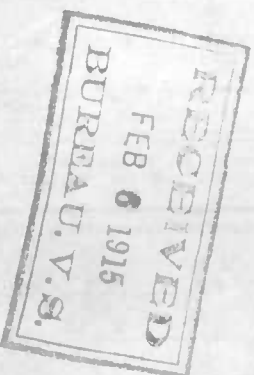
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. *For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| 1 PLACE OF DEATH | | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|---|--|---|---|--|
| County <u>Baltimore</u> | | | Registration Dist. No. <u>41</u> | |
| Village or City <u>Highlandtown</u> (No. <u>3205 E Balto</u>) | | | St.; _____ Ward _____ | |
| 2 FULL NAME <u>No name</u> | | | <u>Murry</u> | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____ | | |
| 6 DATE OF BIRTH <u>1 24 1905</u> (Month) (Day) (Year) | | | | |
| 7 AGE <u>Stillborn</u> | | If LESS than 1 day, _____ hrs. OR _____ min. ? | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>no</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>no</u> | | | | |
| 9 BIRTHPLACE (State or country) <u>3205 E. Balto St</u> | | | | |
| PARENTS | 10 NAME OF FATHER <u>James Murry</u> | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>not known</u> | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Annie Gumpwolf</u> | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Balto Ind.</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | |
| (Informant) _____ | | | | |
| (Address) _____ | | | | |
| 15 <u>Jan 30 1915</u> <u>V. E. McClanahan</u> Filed _____ REGISTRAR | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| 16 DATE OF DEATH <u>24 1915</u> (Month) (Day) (Year) | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 24 1915</u> to <u>Jan 24 1915</u> . that I last saw her alive on <u>Still born</u> , 191_____ | | | | |
| and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Abortion</u> <u>Cause not given</u> (Duration) _____ yrs. _____ mos. _____ ds. | | | | |
| Contributory <u>about 11 mos</u> Secondary <u>Abortion</u> (Duration) _____ yrs. _____ mos. _____ ds. | | | | |
| (Signed) <u>Jan L. Truax</u> , M. D. <u>Jan 26 1915</u> (Address) <u>248 So Third</u> | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____ | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>JHMS</u> | | | DATE OF BURIAL <u>1/25 1915</u> | |
| 20 UNDERTAKER <u>Prosser</u> | | | ADDRESS <u>JHMS</u> | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spais, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 6 1915

BUREAU OF VITALS

RECEIVED
JAN 26 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | |
|---|--|---|---|---|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 326 (42) | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Washington Park</u> (No. <u>Mandlin</u> St.; Ward) | | Registration Dist. No. <u>1421</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |
| 2 FULL NAME <u>Mary Louisa Musgrave</u> | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <u>F</u> | 4 COLOR OR RACE <u>W</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widow</u> (Write the word) | | |
| 6 DATE OF BIRTH <u>Sept 8</u> , 18 <u>59</u> (Month) (Day) (Year) | | | | |
| 7 AGE <u>55</u> yrs. <u>3</u> mos. <u>26</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ? | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>House Work</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | |
| 9 BIRTHPLACE (State or country) <u>Pa</u> | | | | |
| PARENTS | 10 NAME OF FATHER <u>Samuel Reasner</u> | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Pa</u> | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Catherine Luter</u> | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Pa</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary L Myers</u> (Address) <u>Mandlin Ave</u> | | | | |
| 15 Filled <u>Jan 3</u> , 191 <u>5</u> <u>F. H. Ruhl</u> REGISTRAR | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| 16 DATE OF DEATH <u>Jan 3</u> , 191 <u>5</u> (Month) (Day) (Year) | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Dec 1st</u> , 191 <u>4</u> , to <u>Jan 3rd</u> , 191 <u>5</u> , that I last saw her alive on <u>Jan 1st</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>3 A</u> m. | | | | |
| The CAUSE OF DEATH* was as follows: <u>Carcinoma of uterus</u> | | | | |
| (Duration) <u>2</u> yrs. ____ mos. ____ ds. | | | | |
| Contributory (Secondary) <u>Acute Cardiac Dilatation</u> | | | | |
| (Signed) <u>Elmer B. Kremer</u> , M. D. <u>Jan 3rd</u> , 191 <u>5</u> (Address) <u>412 Cathedral</u> | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____ | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>London Park</u> | | | | DATE OF BURIAL <u>Jan 5</u> , 191 <u>5</u> |
| 20 UNDERTAKER <u>William Cook</u> | | | | ADDRESS <u>502 E. 10th</u> |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary). 10 ds. Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 5 1915

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

327

County Baltimore,

81

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Bay View Asylum, (No. CITY HOSPITAL) St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Thomas Nelson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 1 836
(Month) (Day) (Year)

7 AGE 79 yrs. 7 mos. 0 ds. 1 day 0 hrs. 0 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) South Carolina

10 NAME OF FATHER Thomas Nelson

11 BIRTHPLACE OF FATHER (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Martha Creavy

13 BIRTHPLACE OF MOTHER (State or country) South Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address) Bay View

15 Filed Jan 18, 1915 William Baur
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 17th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 5th, 1915 to January 17th, 1915.

that I last saw him alive on January 17th, 1915

and that death occurred on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Senility unknown
(Duration) yrs. mos. ds.

Contributory Arteriosclerosis
Secondary unknown
(Duration) yrs. mos. ds.

(Signed) H. P. McPherson, M. D.
Jan. 18th, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 12 yrs. 0 mos. 0 ds. In the State 12 yrs. 0 mos. 0 ds.

Where was disease contracted, unknown
If not at place of death?

Former or usual residence Unknown Bay View Asylum

19 PLACE OF BURIAL OR REMOVAL Johns Hopkins DATE OF BURIAL Jan 18th, 1915

20 UNDERTAKER H. L. Hurley ADDRESS 1109 7th Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

328

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 43.Village or City Eastville (No. Old Harford Road St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Julius August Charles Neubauer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Dec. 28th, 1899
(Month) (Day) (Year)

7 AGE 65 yrs. 14 mos. 14 ds. If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Masonry
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Reinhold Neubauer

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Gellerman

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wilhelmina Neubauer(Address) Eastville Old Harford Road

15 Filed Jan 12, 1915 W. F. Clayton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 11th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1914 to Jan. 10, 1915.

that I last saw him alive on Jan. 10, 1915

and that death occurred on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder
(Duration) 6 mos. 0 ds.

Contributory Cancer of Bladder
Secondary (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Morris B. Green, M. D.
Jan 11, 1915 (Address) Hamilton Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL St John Cemetery DATE OF BURIAL Jan 14th, 1915

20 UNDERTAKER Grammer & Teufel ADDRESS 1111 Hill

Fulberton

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 4 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

329

County BaltimoreVillage or City Bay View Asylum

(No. _____, St. _____ Ward _____)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Neuman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Unknown
(Write the word)

6 DATE OF BIRTH _____, 1856
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. OR _____ mln. ?
If LESS than 1 day, _____ hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work General Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Unobtainable
11 BIRTHPLACE OF FATHER (State or country) "
12 MAIDEN NAME OF MOTHER "
13 BIRTHPLACE OF MOTHER (State or country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15 Filed Jan 21, 1915 Mrs. Jane Bass
REGISTRAR

CITY HOSPITAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 20th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 9th, 1915, to January 20th, 1915.

that I last saw him alive on January 20th, 1915.

and that death occurred on the date stated above, at 3.30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) unknown yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. C. Princeps, M. D.

Jan. 20th, 1915. (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. 11 ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or usual residence Unknown

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt. Auburn Cem Jan 24, 1915

20 UNDERTAKER ADDRESS

Mrs. H. Hooper 617 Bonell

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. X.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 22 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 330
 County Baltimore
 Village or City Edgemere (No. 91) St. _____ Ward _____
 2 FULL NAME Catherine M. Nizer

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 444

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH Dec 19th, 1915
 (Month) (Day) (Year)

7 AGE 2 yrs. 1 mos. 1 ds. OR 1 day. 1 hrs. 1 min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

10 NAME OF FATHER George H. Nizer
 11 BIRTHPLACE OF FATHER (State or country) Baltimore
 12 MAIDEN NAME OF MOTHER Anna M. Norton
 13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo H. Nizer
 (Address) Spinnis Point R. 78

15 Filed Jan. 19th, 1915 G. (Mc) Mick
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 19th, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 12th, 1915, to Jan 19th, 1915,
 that I last saw her alive on Jan 18th, 1915

and that death occurred on the date stated above, at 4.45 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Drunk)

(Duration) _____ yrs. _____ mos. 5 ds.

Contributory Exhaustion
 Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. L. Giddell, M. D.
Jan 14th, 1915 (Address) Spinnis Point

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Trinity Cem. DATE OF BURIAL Jan 20, 1915

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

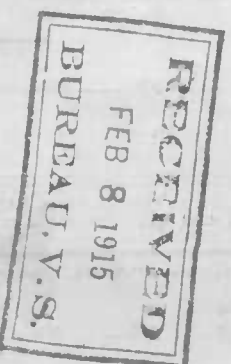
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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331

1 PLACE OF DEATH

County BaltoVillage or City Highlandtown (No. 3922 E Pratt) St.; Ward

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Delaine Notte

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the words)

6 DATE OF BIRTH May 24, 1915
(Month) (Day) (Year)

7 AGE 4 yrs. 7 mos. 13 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Co

PARENTS
10 NAME OF FATHER Carmine Notte
11 BIRTHPLACE OF FATHER (State or country) Italy
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (State or country) Italy

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carmine Notte(Address) 3922 E Pratt

15 Filed Jan 8, 1915 W. E. M. Clavley
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 7, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1914, 191, to Jan 7, 1915, 191.

that I last saw him alive on Jan 7, 1915.

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria
(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) E. J. Passmore, M. D.

Jan 8, 1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Patrick's Cem Jan 8, 1915

20 UNDERTAKER ADDRESS

John Herwig & Co 2008 Orleans

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Scule," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state *CAUSES OF INJURY* as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1915

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH | | | 332 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|--|---------------------------------|---|------|--|---|--|
| County <u>Baltimore</u> | | | (92) | | Registered No. <u>32</u> | |
| Village or City <u>Arlington</u> (No. _____, St.; _____ Ward) | | | | | | |
| 2 FULL NAME <u>Emma Ruth</u> | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | | | | |
| 6 DATE OF BIRTH <u>3</u> <u>10</u> <u>1912</u> (Month) (Day) (Year) | | | | | | |
| 7 AGE <u>2</u> <u>10</u> <u>18</u> <u>ds.</u> yrs. mos. ds. If LESS than 1 day, hrs. OR min. ? | | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | | | | | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | | | | |
| PARENTS | | | | | | |
| 10 NAME OF FATHER <u>Joseph Ruth</u> | | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> | | | | | | |
| 12 MAIDEN NAME OF MOTHER <u>Lone Potts</u> | | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jos. Ruth</u> (Address) <u>Arlington</u> | | | | | | |
| 15 Filed <u>Jan. 29, 1915</u> <u>Wm. G. Queen</u> REGISTRAR | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | |
| 16 DATE OF DEATH <u>1</u> <u>28</u> <u>1915</u> (Month) (Day) (Year) | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan. 24, 1915</u> to <u>Jan. 27, 1915</u> , that I last saw her alive on <u>Jan. 27, 1915</u> , and that death occurred on the date stated above, at <u>1202</u> m. The CAUSE OF DEATH* was as follows: <u>Tubercular Pneumonia</u> | | | | | | |
| (Duration) _____ yrs. _____ mos. <u>4</u> ds. | | | | | | |
| Contributory (Secondary) <u>Traumatic Cerebration</u> <u>Lifetime</u> (Duration) _____ yrs. _____ mos. _____ ds. | | | | | | |
| (Signed) <u>William G. Queen</u> , M. D. <u>Jan. 28, 1915</u> (Address) <u>Arlington Md.</u> | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____ | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>St. Charles Cemetery</u> DATE OF BURIAL <u>Jan 31, 1915</u> | | | | | | |
| 20 UNDERTAKER <u>Chas. J. Kraft</u> ADDRESS <u>Bethesda</u> | | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

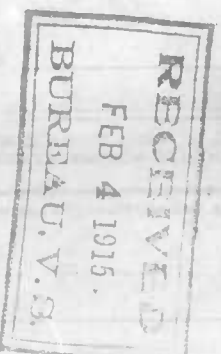
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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333

1 PLACE OF DEATH

County

Village or City

No.

Registration Dist. No.

St.; Ward)

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
Secondary

(Signed)

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

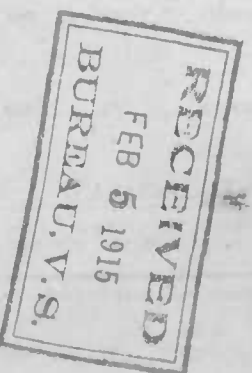
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1 PLACE OF DEATH

334

County BaltimoreVillage or City Balto (No. 28)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Samuel O. Ogley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

negro5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)single

6 DATE OF BIRTH

Jan 6, 1879
(Month) (Day) (Year)

7 AGE

36 yrs. 0 mos. 0 ds. OR 0 min. ?
If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

John O. Ogley

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Phoebe Wilson

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Bay View

15

Filed

Jan 11, 1915 Miriam Barr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 11, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 6, 1915 to Jan 11, 1915that I last saw him alive on Jan 10, 1915and that death occurred on the date stated above, at 3:54 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia pulmonalis(Duration) Unknown ds.Contributory
Secondary(Duration) Unknown yrs. 0 mos. 0 ds.

(Signed)

H. F. Callahan

M. D.

Jan 11, 1915 (Address) City St. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 5 yrs. 0 mos. 0 ds. In the 36 yrs. 0 mos. 0 ds. State

Where was disease contracted,

If not at place of death?

Unknown

Former or usual residence

819 Tessler St

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Auburn CemJan 12, 1915

20 UNDERTAKER

ADDRESS

Robt. Elliott506 East St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH 335
 County Baltimore
 Village or City Bay View Asylum.

CITY HOSPITAL.

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME Louis Olsen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)

6 DATE OF BIRTH 1. 877
 (Month) (Day) (Year)

7 AGE 38 yrs. 38 mos. 38 ds. OR 38 min. ?
 If LESS than 1 day, hrs.

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Fireman
 (b) General nature of industry, business, or establishment in which employed (or employer) Steamships

9 BIRTHPLACE (State or country) Norway

PARENTS
 10 NAME OF FATHER Louis Olsen
 11 BIRTHPLACE OF FATHER (State or country) Norway
 12 MAIDEN NAME OF MOTHER Maggie Larsen
 13 BIRTHPLACE OF MOTHER (State or country) Norway

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Hospital Records
 (Address) Bay View

15 Filed Jan 15, 1915 Miriam Baw
 REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. A.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 13th, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 10th 1915 to January 13, 1915.

that I last saw him alive on January 13th, 1915.

and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Dolereum Tremens

(Duration) 3 yrs. 3 mos. 3 ds.

Contributory
 Secondary

(Signed) U. C. P. R. S., M. D.

Jan. 14th 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. 3 mos. 3 ds. In the State 3 yrs. 3 mos. 3 ds.

Where was disease contracted, unknown

If not at place of death? unknown

Former or usual residence Unknown

19 PLACE OF BURIAL OR REMOVAL Johns Hopkins DATE OF BURIAL Jan 15, 1915

20 UNDERTAKER G. L. Huxley ADDRESS Mag. 7. Helmer

EX.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

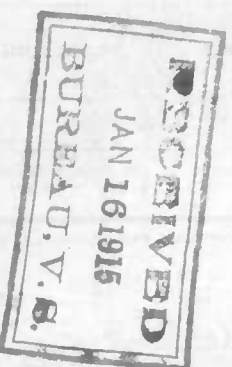
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line, will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Workman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

336

STATE OF MARYLAND
CERTIFICATE OF DEATH

County Baltimore

Village or City Owens Mills

(No. 91)

Rosewood State Training School

Registered No. 33

St. Ward

If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Nichols Parker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH January 29, 1907
(Month) (Day) (Year)

7 AGE 8 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment to which employed (or employer) None

9 BIRTHPLACE (State or country) Maryland

PARENTS 10 NAME OF FATHER Jas. E. Parker
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Lillian Garner
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kenneth B. Jones
(Address) Owens Mills

15 Filed July 29, 1915 Wm. Slack
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 29, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1915 to July 28, 1915, that I last saw him alive on July 28, 1915

and that death occurred on the date stated above, at 4:30 a. m.
The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) Idiocy

(Duration) 8 yrs. — mos. — ds.

(Signed) Kenneth B. Jones, M. D.
July 29, 1915 (Address) Owens Mills Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 yrs. — mos. — ds. to the State 8 yrs. — mos. — ds.

Where was disease contracted? Upper Marlboro Md.
If not at place of death? On Route from
Former or usual residence Upper Marlboro Md.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Upper Marlboro Jan 30, 1915
20 UNDERTAKER ADDRESS
J. F. Elnor Reisterstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

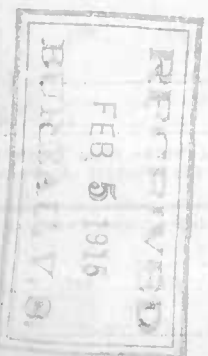
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager." "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Saddle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

337

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City Loch Raven (No. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

*FULL NAME John S. Parks

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH April 16, 1844
(Month) (Day) (Year)

7 AGE 68 yrs. 9 mos. 14 ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Peter Parks

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susie Woodson

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Katherine Parks(Address) Loch Raven Md.

15 Filed Feb 1st, 1915 Claud Shivers
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 30, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 1912, to Jan 30th, 1915.

that I last saw him alive on Jan. 30th, 1915

and that death occurred on the date stated above, at 3:25 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
SecondaryArterio Sclerosis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Daniel F. R. Thos. Jones, M. D.
Jan 30th, 1915. (Address) Dorowood, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR CREMATION Salem Cemetery
Balto. Co., Md. DATE OF BURIAL Feb. 2nd, 1915

20 UNDERTAKER Slade Bros. ADDRESS Louie Green

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

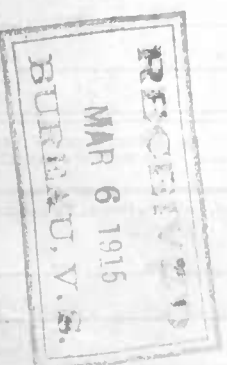
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | |
|---|---------------------------------|---|--|---|
| 1 PLACE OF DEATH | | 338 | STATE OF MARYLAND | |
| County <u>Baltimore</u> | | (91) | CERTIFICATE OF DEATH | |
| Village or City <u>Bay View Asylum</u> | | (No.) | Registration Dist. No. <u>41</u> | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |
| 2 FULL NAME <u>William Patterson</u> | | CITY HOSPITAL | | |
| PERSONAL AND STATISTICAL PARTICULARS | | MEDICAL CERTIFICATE OF DEATH | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Black</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | 16 DATE OF DEATH <u>January 23rd</u> , 191 <u>5</u> (Month) (Day) (Year) | |
| 6 DATE OF BIRTH, 18 <u>41</u> (Month) (Day) (Year) | | 17 I HEREBY CERTIFY, That I attended deceased from <u>January 11th</u> 191 <u>5</u> to <u>January 23rd</u> 191 <u>5</u> . | | |
| 7 AGE <u>74</u> yrs. mos. ds. OR min. ? | | that I last saw him alive on <u>January 23rd</u> , 191 <u>5</u> . | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | and that death occurred on the date stated above, at <u>5.55 Pm</u> . | | |
| 9 BIRTHPLACE (State or country) <u>South Carolina</u> | | The CAUSE OF DEATH* was as follows: <u>Bronchopneumonia</u> | | |
| 10 NAME OF FATHER <u>Unknown</u> | | Contributory (Duration) yrs. mos. <u>2</u> ds. Secondary <u>Senility</u> | | |
| 11 BIRTHPLACE OF FATHER (State or country) " | | (Signed) <u>M. E. Pincus</u> , M. D. | | |
| 12 MAIDEN NAME OF MOTHER " | | Jan. <u>24th</u> , 191 <u>5</u> (Address) <u>CITY HOSPITAL</u> | | |
| 13 BIRTHPLACE OF MOTHER (State or country) " | | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hospital Records</u> (Address) <u>Bay View</u> | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. <u>12</u> ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence <u>Unknown</u> | | |
| 15 Filed <u>Jan 25</u> , 191 <u>5</u> <u>Mrs. M. B. Burr</u> REGISTRAR | | 19 PLACE OF BURIAL OR REMOVAL <u>Johns Hopkins</u> DATE OF BURIAL <u>Jan 25</u> , 191 <u>5</u> 20 UNDERTAKER <u>G. L. Harlow</u> ADDRESS <u>1109 N. Helmer St.</u> | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

339

County Baltimore

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Bay View Asylum (No. GITY HOSPITAL St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jessie Payne

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 1.889
(Month) (Day) (Year)

7 AGE 26 yrs. 0 mos. 0 ds. 0 OR 1 day, 0 hrs. 0 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) North Carolina

10 NAME OF FATHER Ike Payne

11 BIRTHPLACE OF FATHER (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Flora Gross

13 BIRTHPLACE OF MOTHER (State or country) North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Bay View

15 Filed Jan 28, 1915 Thirion Bess
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 27th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 21st, 1915 to January 27th, 1915.

that I last saw him alive on January 27th, 1915

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) unknown yrs. 0 mos. 0 ds.

Contributory
Secondary

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) W. C. Chappelle, M. D.

Jan. 27, 1915. (Address) GITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 6 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, unknown
If not at place of death?

Former or usual residence 1404 Penna. Ave.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt. Auburn Cem. Jan 29, 1915

20 UNDERTAKER ADDRESS

John H. Owens 1222 Division

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

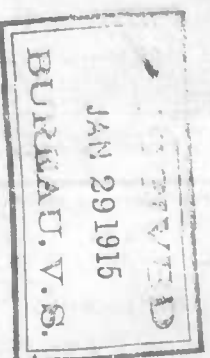
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scuffle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH | | 340 | | 159 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|---|---|---|--|---|--|---|--|
| County <u>Baltimore</u> | | <u>15th District</u> | | Registration Dist. No. <u>44</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| Village or City <u>North Point Road near Eastern Ave.</u> | | (No. <u> </u>) | | St. <u> </u> Ward <u> </u> | | | |
| 2 FULL NAME <u>George Priper</u> | | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | |
| 3 SEX <u>Male</u> | | 4 COLOR OR RACE <u>White</u> | | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>Single</u> | | | |
| 6 DATE OF BIRTH <u>March 14, 1875</u> | | (Month) (Day) (Year) | | | | | |
| 7 AGE <u>39</u> yrs. <u>9</u> mos. <u>27</u> ds. | | If LESS than 1 day, hrs. OR min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Day Laborer</u> | | (b) General nature of industry, business, or establishment in which employed (or employer) <u>American Tobaccos Co.</u> | | | | | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Carl F. A. Priper</u> | | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> | | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Fredericka Greenwald</u> | | | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u> | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | | | |
| (Informant) <u>Philip Herwig</u> | | | | | | | |
| (Address) <u>2016 Orleans St.</u> | | | | | | | |
| 15 Filed <u>Jan 12, 1915</u> | | <u>G. W. Harrison</u> | | REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | |
| 16 DATE OF DEATH <u>January 11, 1915</u> | | (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u> </u> , 191 <u> </u> , to <u> </u> , 191 <u> </u> . | | | | | | | |
| that I last saw him alive on <u> </u> , 191 <u> </u> . | | | | | | | |
| and that death occurred on the date stated above, at <u>5:45 a.m.</u> | | | | | | | |
| The CAUSE OF DEATH* was as follows: <u>Self inflicted wound produced by revolver of 32 Caliber. Bullet penetrating the heart. Suicidal intent.</u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. | | | | | | | |
| Contributory <u> </u> Secondary <u> </u> | | | | | | | |
| (Signed) <u>A. R. H. Hussey</u> Coroner, M. D. <u>Jan 12, 1915</u> (Address) <u>Colgate Md.</u> | | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | | | |
| At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. | | In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. | | | | | |
| Where was disease contracted, if not at place of death? <u> </u> | | | | | | | |
| Former or usual residence <u> </u> | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Trinity Cem.</u> | | | | DATE OF BURIAL <u>Jan 13, 1915</u> | | | |
| 20 UNDERTAKER <u>Philip Herwig</u> | | | | ADDRESS <u>2016 Orleans</u> | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

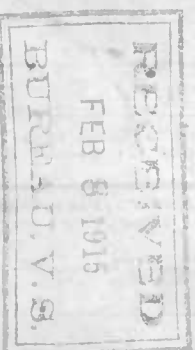
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Droup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County BaltimoreVillage or City Foreston

(No.)

St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 34

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Stephen Armauer Peregoy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

February Sixth 1886
(Month) (Day) (Year)

7 AGE

78 yrs. 10 mos. 26 ds.

If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Baltimore County

PARENTS

10 NAME OF FATHER

Dont know

11 BIRTHPLACE OF FATHER (State or country)

Dont know

12 MAIDEN NAME OF MOTHER

Dont know

13 BIRTHPLACE OF MOTHER (State or country)

Dont know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George W. Peregoy

(Address)

Box 91 Parkton Ind.

15

Filed

Jan 22, 1915Thosna McKill
Dep. Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 3, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec 30 th, 1914, to Jan 1st, 1915that I last saw him alive on Jan 1st, 1915and that death occurred on the date stated above, at 6. a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction(Duration) 0 yrs. 0 mos. 3 ds.

Contributory (Secondary)

Old Age(Duration) 0 yrs. 0 mos. 0 ds.(Signed) L. H. Resh, M. D.Jan 1st, 1915 (Address) Baltimore Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Foreston Ind.Jan 4, 1915

20 UNDERTAKER

ADDRESS

Larry Stiffles Balto City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 8 1915

BUREAU. V. S.

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1 PLACE OF DEATH

342

County BaltimoreBay View Asylum

Village or City (No. _____)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Bessie Post

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH _____, 1895
(Month) (Day) (Year)

7 AGE 19 yrs. _____ mos. _____ ds. OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Joseph Post
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary Gunning
13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records
(Address) Bay View

15 Filed Jan 10, 1915 Miriam Bair
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Jan 9, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1914, to Jan 9, 1915
that I last saw her alive on Jan 9, 1915

and that death occurred on the date stated above, at 9.45 pm.
The CAUSE OF DEATH* was as follows:

catarrh of
Pulmonary

(Duration) yrs. 7 mos. _____ ds.

Contributory Tubercular calcification
Secondary

(Duration) unknown yrs. _____ mos. _____ ds.

(Signed) F. F. Callahan, M. D.
Jan 9, 1915 (Address) City 11 Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. 6 mos. 28 ds. In the _____ State 19 yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? unknown

Former or usual residence 3 N. Pearl St.

19 PLACE OF BURIAL OR REMOVAL Bonnie B. B. B. DATE OF BURIAL Jan 12, 1915

20 UNDERTAKER J. J. Cowan ADDRESS 901 Hollins

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

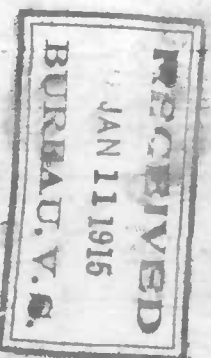
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH 343

County Baltimore

(31)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Catonsville (No. Smithwood Ave. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mamie M. Porter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Nov. 27, 1891
(Month) (Day) (Year)

7 AGE 23 yrs. 1 mos. 21 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Baltimore Co. Md.

10 NAME OF FATHER Edward T. Porter

11 BIRTHPLACE OF FATHER (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Anna V. Smith

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward T. Porter(Address) Smithwood Ave.

15 Filed Jan 19, 1915 Marshall B. Ursf.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1915 to Jan 18, 1915.

that I last saw him alive on Jan 18, 1915and that death occurred on the date stated above, at 10:10 a.m.

The CAUSE OF DEATH* was as follows:

Tubercular Proctitis(Duration) 1 yrs. + mos. + ds.Contributory
Secondary(Duration) — yrs. — mos. — ds.

(Signed) Dr. Delaney Thomas, M. D.
Jan 19, 1915 (Address) 612 Professor's Bldg.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Oliver Jan 20, 1915

20 UNDERTAKER ADDRESS
Geo W Little 531 N. Fremont
Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

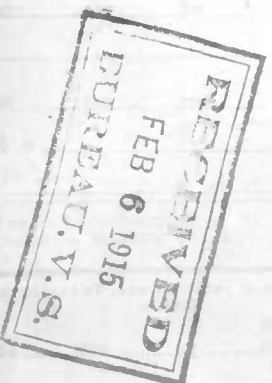
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not painfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scull," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhag," "Iuandition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

344

County BaltimoreVillage or City Rossville (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Christina Ramseyer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the words)Single

6 DATE OF BIRTH

1 17 1915
(Month) (Day) (Year)

7 AGE

— yrs. — mos. 2 ds. OR — min. ?
It LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None9 BIRTHPLACE
(State or country)Maryland

PARENTS

10 NAME OF FATHER

Nicholas Ramseyer11 BIRTHPLACE OF FATHER
(State or country)Europe

12 MAIDEN NAME OF MOTHER

Mary Smith13 BIRTHPLACE OF MOTHER
(State or country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nicholas Ramseyer(Address) Rossville Ind

15

Filed Jan 19 1915 H. F. Clayton

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 19 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from

Jan 17 1915 to Jan 14 1915,
that I last saw her alive on Jan 18 1915and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
7 months

(Duration) yrs. mos. ds.

Contributory
Secondary(Signed) E. Villace, M. D.
1/19 1915 (Address) Rossville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

Emmanuel Cemetery

DATE OF BURIAL

Jan 20th 1915

20 UNDERTAKER

Federick Lasschu & Sons Fullerton Ind.

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, STRUCK, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 4 1915

BUREAU U. S. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | |
|--|--|--------------------------|---|---|
| 1 PLACE OF DEATH County <u>Balto. Co</u> | | 345 <u>28</u> | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Arlington</u> (No. <u>106 W. Virginia Ave</u>) | | Registered No. <u>35</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |
| 2 FULL NAME <u>Lena L. Rauck</u> | | | | |

| PERSONAL AND STATISTICAL PARTICULARS | | MEDICAL CERTIFICATE OF DEATH | |
|---|---------------------------------|---|--|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u> | 16 DATE OF DEATH <u>Jan 23rd</u> , 191 <u>5</u> (Month) (Day) (Year) |
| 6 DATE OF BIRTH <u>1881</u> (Month) (Day) (Year) | | 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 17th</u> , 191 <u>5</u> , to <u>Jan 23</u> , 191 <u>5</u> , that I last saw h. <u>alive</u> on <u>Jan 22</u> , 191 <u>5</u> and that death occurred on the date stated above, at <u>6:10 A</u> m, The CAUSE OF DEATH* was as follows: <u>Pulmonary & Laryngeal</u> <u>Tuberculosis</u> (Duration) <u>6</u> yrs. <u>—</u> mos. <u>—</u> ds. | |
| 7 AGE <u>34</u> yrs. <u>—</u> mos. <u>—</u> ds. OR <u>1</u> day, <u>—</u> hrs. <u>—</u> min. ? | | Contributory (Secondary) <u>Heart failure</u> (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u> | | (Signed) <u>John D. Bubert</u> M. D. <u>Jan 23</u> , 191 <u>5</u> (Address) <u>4836 Park Heights Ave</u> | |
| 9 BIRTHPLACE (State or country) <u>W. Va.</u> | | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | |
| 10 NAME OF FATHER <u>Chas. Admeyer</u> | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>1</u> yrs. <u>14</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u>—</u> | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>MD.</u> | | 19 PLACE OF BURIAL OR REMOVAL <u>Midway Park</u> <u>Prophetstown Md</u> | |
| 12 MAIDEN NAME OF MOTHER <u>Emmi Lemen</u> | | DATE OF BURIAL <u>Jan 24</u> , 191 <u>5</u> | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>W. Va.</u> | | 20 UNDERTAKER <u>Samuel Easton</u> <u>Berman</u> | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Chas. B. Rauck</u> (Address) <u>106 W. Virginia Ave</u> | | | |
| 15 Filed <u>Jan 23</u> , 191 <u>5</u> <u>Harry C. Kayser</u> REGISTRAR | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

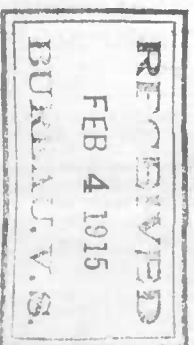
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FEB 8 1915

BUREAU U. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | |
|--|---------------------------------|--|--|---|--|
| 1 PLACE OF DEATH County <u>Balto.</u> | | 347 <u>(19)</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Raspburg</u> (No. <u>221</u> Cole Ave. St., Ward) | | Registered No. <u>43</u> | | [If death occurred to a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Louis Renneburg</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u> | | | |
| 6 DATE OF BIRTH <u>January 30th, 1857</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>57</u> yrs. <u>11</u> mos. <u>26</u> ds. | | If LESS than 1 day, ... hrs. OR ... min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Baker</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Retired</u> | | | | | |
| 9 BIRTHPLACE (State or country) <u>Germany</u> | | | | | |
| PARENTS | | | | | |
| 10 NAME OF FATHER <u>Henry Renneburg</u> | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> | | | | | |
| 12 MAIDEN NAME OF MOTHER <u>Lora Walliche</u> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Rena Luers.</u> <u>221 Cole Ave. Raspburg.</u> (Address) | | | | | |
| 15 <u>Jan 28</u> , 1915 <u>W. H. Clayton</u> Filed REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>January 25th, 1915</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, that I attended deceased from <u>January 24th, 1915</u> to <u>January 25th, 1915</u> , that I last saw him alive on <u>January 24th, 1915</u> , and that death occurred on the date stated above, at <u>7⁵⁰ P. m.</u> | | | | | |
| The CAUSE OF DEATH* was as follows: <u>Dilatation of the Heart</u> <u>Chronic Valvular Heart</u> <u>Failure</u> (Duration) <u>1</u> yrs. <u>—</u> mos. <u>1</u> ds. (Signed) <u>W. A. Meyer</u> , M. D. <u>January 25th, 1915</u> (Address) <u>1031 N. Caroline St. Balt. Md.</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds. Where was disease contracted, If not at place of death? Former or usual residence... | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Oak Lawn Cem.</u> | | | | DATE OF BURIAL <u>Jan. 28th, 1915</u> | |
| 20 UNDERTAKER <u>Robt. J. Zumer</u> | | | | ADDRESS <u>1442 N. Bräwiy</u> | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

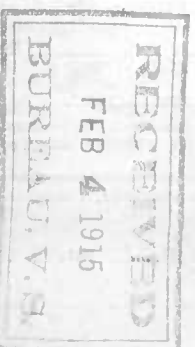
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH | | 348 | | STATE OF MARYLAND | |
|---|--|--|--|---|--|
| County | | (77) | | CERTIFICATE OF DEATH | |
| Village or City | | No. 121 S. 3 rd | | Registration Dist. No. 41 | |
| 2 FULL NAME | | Andrew P. Renner | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | | | |
| Male | White | Married | | | |
| 6 DATE OF BIRTH | Feb 12 th , 1847 | | | | |
| 7 AGE | 67 yrs. 11 mos. ds. OR 1 day, hrs. min. ? | | | | |
| 8 OCCUPATION | Iron Moulder | | | | |
| (a) Trade, profession, or particular kind of work. | Moulder in foundry | | | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | Penn | | | | |
| 9 BIRTHPLACE (State or country) | Pa. | | | | |
| PARENTS | 10 NAME OF FATHER | Geo. Renner | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) | Pa. | | | |
| | 12 MAIDEN NAME OF MOTHER | Unknown | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) | Pa. | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | |
| (Informant) Mary E. Renner | | | | | |
| (Address) 121 S. 3 rd St. | | | | | |
| 15 | Filed Jan 14, 1915 | | | | |
| REGISTRAR | | | | | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH Jan 12, 1915 | | | | | |
| (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1915 to Jan 12, 1915. | | | | | |
| that I last saw him alive on Jan 11, 1915 | | | | | |
| and that death occurred on the date stated above, at 10 30 a.m. | | | | | |
| The CAUSE OF DEATH* was as follows: | | | | | |
| Thrombosis | | | | | |
| Pericarditis | | | | | |
| (Duration) 2 yrs. 2 mos. 9 ds. | | | | | |
| Contributory Mitral Insufficiency | | | | | |
| (Duration) 2 yrs. 3 mos. 3 ds. | | | | | |
| (Signed) Jas. L. Gray, M. D. | | | | | |
| Jan 12, 1915 (Address) 248 So. 10th | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | |
| At place of death yrs. mos. ds. In the State yrs. mos. ds. | | | | | |
| Where was disease contracted, If not at place of death? | | | | | |
| Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL | | | | | |
| Frederick Md | | | | | |
| DATE OF BURIAL Jan 15, 1915 | | | | | |
| 20 UNDERTAKER | | | | | |
| Philip Herwig | | | | | |
| ADDRESS 2016 Orleans | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

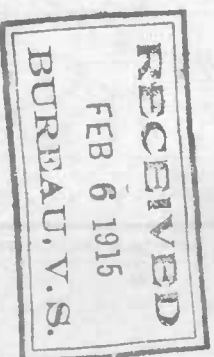
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Baltimore

349

(157)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highlandtown

(No. 26

S. East Ave

St;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Gorthea M. Reynolds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

W.

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

*Oct.**7**1914*

(Month)

(Day)

(Year)

7 AGE

*4**mos.**21**ds.*

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Arthur R Reynolds

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sarah E. Thomas

13 BIRTHPLACE OF MOTHER

(State or country)

Wales

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur R Reynolds

(Address)

25 S. East Ave

15

Filed

*Jan. 30, 1915**W. E. McLaughlin*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Jan. 28th**1915*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

*Oct 7**1914**to Jan 28**1915*

that I last saw him alive on

*Jan 28**1915*and that death occurred on the date stated above, at *12:25 P.* m.

The CAUSE OF DEATH* was as follows:

Inanition(Duration) yrs. *4* mos. *21* ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

John Haff

M. D.

*Jan 29th**1915*

(Address)

15 N. Monroe St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

.... yrs. mos. ds.

In the

State

.... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cemetery**JAN 30 1915*

20 UNDERTAKER

ADDRESS

Geo. A. Gerbig Balto & Payson

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

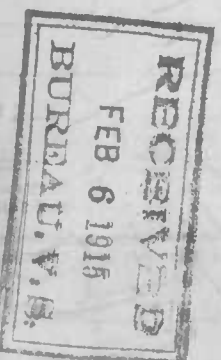
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[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

350

County Baltimore

Village or City

Owles

(No.

St.: Ward)

Registration Dist. No.

43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Eliza Reynolds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married.

6 DATE OF BIRTH

17 31 1846
(Month) (Day) (Year)

7 AGE

68 yrs. 0 mos. 30 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Domestic work in her own home

(b) General nature of industry, business, or establishment in which employed (or employer)

" " " "

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Thomas Dorsey

11 BIRTHPLACE OF FATHER (State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Mary R. Johns

13 BIRTHPLACE OF MOTHER (State or country)

Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Est. Dume

(Address)

Owles.

15

Filed

Jan 31, 1915W. H. Kayser

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 30 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

1-28 1915 to 1-30 1915that I last saw her alive on 1-30 1915and that death occurred on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. mos. ds.

Contributory
Secondary(Probably) Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

(Signed)

A. T. Millarison

M. D.

1-30 1915 (Address) Raspburg

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16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

West Olivet Cemetery Feb 2 1915

20 UNDERTAKER

ADDRESS

Frederick Gossman 2405 Fullerton Ind.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

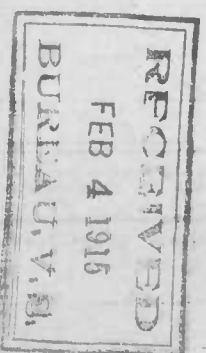
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1 PLACE OF DEATH

County BaltimoreVillage or City St. Agnes Hospital (No. 79)St. Ward Registration Dist. No. 42

[If death occurred to a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mr. Wesley S. Rigby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Feb 21, 1864
(Month) (Day) (Year)

7 AGE 50 yrs. 11 mos. 6 ds. OR 1 day, hrs. min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Henry Rigby

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mandy Bozman

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Christopher Lahn

(Address) 2539 Frederick Ave

15 Filed Jan 27, 1915 Henry H. Loos
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 27, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1915 to Jan 27, 1915

that I last saw him alive on Jan 27, 1915

and that death occurred on the date stated above, at 7:50 p.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. ds.
Contributory Myocarditis
Secondary

(Signed) Jas. H. Catzburger, M. D.
Jan 27, 1915 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence 2539 Frederick Ave

19 PLACE OF BURIAL OR REMOVAL Oella Md. DATE OF BURIAL Jan 31, 1915

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

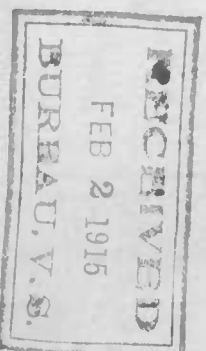
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Traema," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscearriage as "Puerperal septicac-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For vio-lent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—acci-dent; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory" (Recommendations: on statement of cause of death approved by Committee on Nomencla-ture of the American Medical Association.)

If this certificate is looked over thoroughly and all ques-tions answered in detail, it will prevent further correspond-ence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

352

County BaltimoreVillage or City Towson (No. 91) St. Ward

FULL NAME

Margaret RobersonSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH May 23, 1913
(Month) (Day) (Year)

7 AGE 1 yrs. 6 mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto-boly

10 NAME OF FATHER Thomas Myres

11 BIRTHPLACE OF FATHER (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Alice Roberson

13 BIRTHPLACE OF MOTHER (State or country) Balto Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice Roberson(Address) Towson

15 Filed Jan 7th, 1915 Claus J. J. J.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 7, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 1915, to Jan 7th, 1915, that I last saw him alive on Jan 6th, 1915

and that death occurred on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)(Duration) yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.(Signed) W. J. J. J., M. D.Jan 7th, 1915 (Address) Towson, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pleasant Rest Cem., Jan. 8th, 1915

20 UNDERTAKER

ADDRESS

John Burns Sons Towson.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

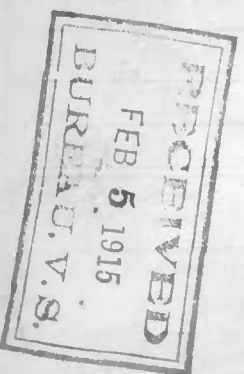
Approved by U. S. Census and American Public Health Association.)

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 353
 County Baltimore
 Village or City Columbia (No. 120) Andry Sanatorium St. Ward Registration Dist. No. 30
 2 FULL NAME Eleonor Refuson

[It death occurred in a hospital or institution, give its NAME instead of street and corner.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)

6 DATE OF BIRTH 1883
 (Month) (Day) (Year)

7 AGE 32 yrs. 3 mos. 0 ds. 1 day, 0 hrs. OR 0 min. ?
 If LESS than 1 day, 0 hrs. 0 min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md.

PARENTS
 10 NAME OF FATHER Joseph Sweitzer
 11 BIRTHPLACE OF FATHER (State or country) Md.
 12 MAIDEN NAME OF MOTHER Mary J. Spland
 13 BIRTHPLACE OF MOTHER (State or country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Sweitzer
 (Address) 725 N. Myrtle St.

15 Filed Jan 15, 1915 Marshall B West
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 30

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 18 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1914, to Jan 15, 1915,
 that I last saw h. lx alive on Jan 15, 1915.

and that death occurred on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) ten yrs. 0 mos. 0 ds.
 Contributory Pulmonary Edema
 Secondary

(Duration) 1 yrs. 0 mos. 0 ds.
 (Signed) Agnes J. Lunday, M. D.
Jan 15, 1915 (Address) Robert Stevenson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death 23 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
 Where was disease contracted, Raleigh N. C.
 If not at place of death?
 Former or usual residence Baltimore Md

19 PLACE OF BURIAL OR REMOVAL New Cathedral Cemetery DATE OF BURIAL 1/18/15
 20 UNDERTAKER A. Fitzpatrick ADDRESS 2438 W North Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

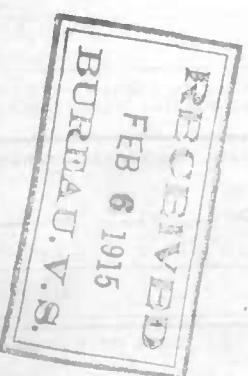
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., *of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic vesicular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

354

County Lutherville Md
Baltimore Co

Village or City Lutherville (No. _____)

2 FULL NAME Not named

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 37

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Robinson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Still born Jan 11th 1915
(Month) (Day) (Year)

7 AGE About 7 months in utero If LESS than 1 day, ____ hrs. ____ min. ?
____ yrs. ____ mos. ____ ds.

8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment to which employed (or employer) _____

9 BIRTHPLACE (State or country) Lutherville Md

10 NAME OF FATHER Judge Robinson

11 BIRTHPLACE OF FATHER (State or country) N Carolina

12 MAIDEN NAME OF MOTHER Lizzie Maulsby or Elizabeth Moncrief

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Judge Robinson
Chalmers Peckles

(Address) Lutherville Md

15 Filed Jan 12, 1915 J. L. Drach M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Still born Jan 11th 1915
January (Month) 11 (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him _____ alive on _____, 191____,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Mother had Convulsions for a week before Still birth baby was delivered

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) _____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Chalmers Peckles, M. D.

Jan 11th 1915 (Address) Lutherville

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. To the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Glen Cemetery Loomis DATE OF BURIAL Jan 12, 1915

20 UNDERTAKER John Burris Sons ADDRESS Towson Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

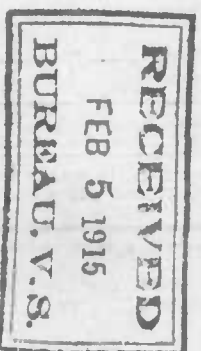
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH

355

County Baltimore

79

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 42Village or City St. Agnes Hospital (No.)St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rev. Aloysius Romano S.J.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH March 21, 1842
(Month) (Day) (Year)

7 AGE 72 yrs. 9 mos. 28 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Clergyman
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Italy

10 NAME OF FATHER Saverino Romano

11 BIRTHPLACE OF FATHER (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Monturiso

13 BIRTHPLACE OF MOTHER (State or country) Italy

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rev. A. Romano S.J.(Address) Woodstock Md.15 Filed Jan. 19, 1915 A. H. Loos

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 19, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1914 to Jan. 19, 1915

that I last saw him alive on Jan. 19, 1915

and that death occurred on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency & Arterio Sclerosis

(Duration) 2 yrs. mos. ds.

Contributory Pulmonary Edema
Secondary

(Duration) 1 yrs. mos. ds.

(Signed) Robert C. White, M. D.

Jan. 19, 1915 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. 12 mos. 12 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Woodstock College, Woodstock Md.

19 PLACE OF BURIAL OR REMOVAL Woodstock College DATE OF BURIAL , 1915

20 UNDERTAKER A. H. Loos ADDRESS Edlicott City, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

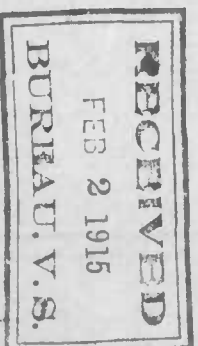
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Baltimore

Village or City Lafayette

2 FULL NAME Caroline Rosenburt

356

(92)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 1421

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

(No. _____ St. _____ Ward)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH September 1
(Month) (Day) (Year)

7 AGE 62 yrs. — mos. — ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis arr

(Address) 1250 Riverside Ave.

15 Filed Jan 9, 1915 L. H. Ruhl

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 8, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1915 to Jan 8, 1915
that I last saw her alive on Jan 8, 1915

and that death occurred on the date stated above, at 8:10 a.m.
The CAUSE OF DEATH* was as follows:

Later pneumonia

(Duration) 3 yrs. 0 mos. 2 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Raymond S. Green, M. D.
Jan 2, 1915 (Address) Unknown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore cemetery DATE OF BURIAL Jan. 12, 1915

20 UNDERTAKER Wm. Carr ADDRESS 502 E. North Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

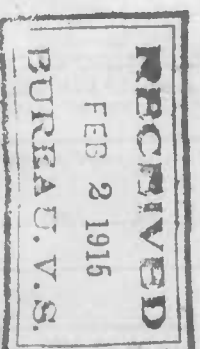
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is inadequate); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH Baltimore 357
 County Baltimore (28)
 Village or City Towson (No. Euclidwood Lane St.; Ward) Registration Dist. No. 38
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

*FULL NAME John J. Rott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH Jan 10, 1886
 (Month) (Day) (Year)

7 AGE 29 yrs. 2 mos. 2 ds. OR 1 day, 1 hrs. If LESS than 1 day,.....hrs.
 OR.....min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Casket maker
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

10 NAME OF FATHER Frank Rott

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Minette Krumholz

(Address) Euclidwood Lane

15 Filed Jan 17, 1915 Clara Smith
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 12, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1914, to Jan 12, 1915,
 that I last saw him alive on Jan 11, 1915

and that death occurred on the date stated above, at 5.50 AM

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 6 mos. 2 ds.
 Contributory Tuberculosis (Pulmonary)
 Secondary

(Signed) Martin J. Sloan, M. D.
Jan 12, 1915. (Address) Euclidwood Lane, Towson, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 3 mos. 3 ds. In the State 1 yrs. 6 mos. 2 ds.

Where was disease contracted, 122 S. Clinton St. 1203

If not at place of death? Former or usual residence. Patterson Park Ave. Baltimore

19 PLACE OF BURIAL OR REMOVAL Sacred Heart Cemetery DATE OF BURIAL Jan 15, 1915

20 UNDERTAKER Joe J. Kerr ADDRESS 1914 E. Fayette

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

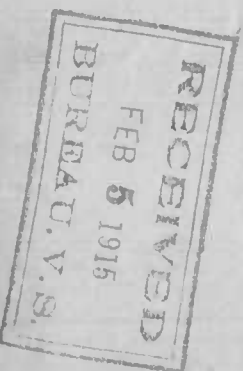
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

358

County Baltimore

(18)

Village or City Beckleysville (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Catherine SoubleRegistration Dist. No. 35

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH November 12, 1847
(Month) (Day) (Year)

7 AGE 67 yrs. 2 mos. 2 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Carroll Co. Md.

PARENTS
10 NAME OF FATHER Feldy Yost
11 BIRTHPLACE OF FATHER (State or country) Don't know
12 MAIDEN NAME OF MOTHER Don't know
13 BIRTHPLACE OF MOTHER (State or country) Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Alban(Address) Hampstead Md

15 Filed Jan. 17, 1915 Joseph S. Duedman
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 14, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1915 to Jan. 14, 1915, that I last saw her alive on Jan. 14, 1915

and that death occurred on the date stated above, at 11:45 P.m.

The CAUSE OF DEATH* was as follows:

Erysipelas(Duration) _____ yrs. _____ mos. 12 ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Sherman, M. D.
Jan. 15, 1915 (Address) Manchester Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Beckleysville Cemetery Jan. 17, 1915
20 UNDERTAKER ADDRESS
LeRoy Skiffles Pockton Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

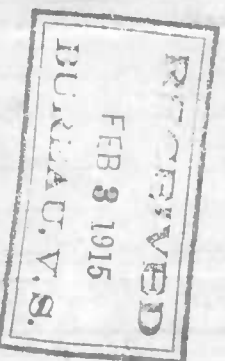
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| 1 PLACE OF DEATH | | 379 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|---|-----------------------------------|--|--|---|--|
| County <u>Baltimore</u> | | (120) | | Registered No. <u>38</u> | |
| Village or City <u>Baltimore</u> | | (No. <u>199</u> , <u>Fall Road</u> | | St.; Ward) | |
| 2 FULL NAME <u>Manda Taylor</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u> | | | |
| 6 DATE OF BIRTH <u>June 28, 1862</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>52</u> yrs. <u>6</u> mos. <u>12</u> ds. If LESS than 1 day, hrs. OR min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Crochman</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Private Family</u> | | | | | |
| 9 BIRTHPLACE (State or country) <u>St. Marys Co Md</u> | | | | | |
| 10 NAME OF FATHER <u>James Taylor</u> | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>St. Marys Co Md</u> | | | | | |
| 12 MAIDEN NAME OF MOTHER <u>Ely Mason</u> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>St. Marys Co Md</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Manda Taylor</u> (Address) <u>199 Fall Road</u> | | | | | |
| 15 Filed <u>Jan 10</u> , 191 <u>5</u> <u>Charles L. Smith</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>January 9th</u> , 191 <u>5</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Nov. 1st</u> , 191 <u>4</u> , to <u>Jan 9th</u> , 191 <u>5</u> , that I last saw him alive on <u>Jan 8th</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>5:30</u> m, The CAUSE OF DEATH* was as follows: <u>Chronic Nephritis; Mitral Regurgitation;</u> <u>Atherosclerosis. (General)</u> <u>Hydrothorax, Pleurisy, Anasarca (6 months)</u> (Duration) yrs. mos. ds. Contributory (Secondary) <u>Myocardial insufficiency</u> (Duration) yrs. mos. ds. (Signed) <u>Raymond H. Huxley</u> , M. D. (Address) <u>Baltimore, Md.</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>St. Peters Cem</u> DATE OF BURIAL <u>Jan 12th</u> , 191 <u>5</u> | | | | | |
| 20 UNDERTAKER <u>Wm. M. Gault</u> ADDRESS <u>401 W. North Ave.</u> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 5 1915
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

359

County

Baltimore

(S)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

38

Village or City

Lanrsale

(No.

Gundm Lane

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Jane Elizabeth Schaffer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Infant

6 DATE OF BIRTH

Jan 16 18

1915

(Month)

(Day)

(Year)

7 AGE

Still born

If LESS than
1 day, hrs.

yrs.

mos.

ds.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Infant

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF
FATHER

John Schaffer

11 BIRTHPLACE
OF FATHER

(State or country)

Maryland

12 MAIDEN NAME
OF MOTHER

Mary Shumik

13 BIRTHPLACE
OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mary Schaffer

(Address)

Lanrsale, Md

15

Filed

Jan 16, 1915

Clara Sumner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 16

1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Still born

1915, to

1915,

that I last saw him alive on 1915

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

Clara Sumner

M. D.

Jan 16

1915 (Address)

Lanrsale, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Some place

Jan 16

1915

20 UNDERTAKER

ADDRESS

Father of child

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

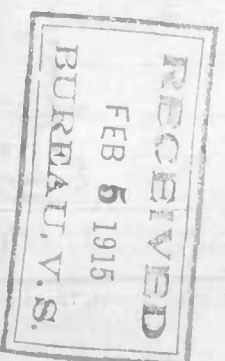
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Baltimore

View Asylum

Village or City Baltimore (No. 28) MUNICIPAL TUBERCULOSIS HOSP.Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Henry Schriener

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH 1888
(Month) (Day) (Year)

7 AGE 27 yrs. 0 mos. 0 ds. If LESS than 1 day, hrs. 0 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Patron
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Schriener

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15 Filed Jan 12, 1915 Marian Barr
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 11, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1914 to Jan 11, 1915

that I last saw him alive on Jan 11, 1915

and that death occurred on the date stated above, at 7:50 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis pulmonalis
(Duration) 5 yrs. 0 mos. 0 ds.

Contributory Tuberculosis of kidneys
Secondary intestine, lungs (Duration) Unknown ds.

(Signed) J. F. Callahan, M. D.
Jan 12, 1915 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 2 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, Unknown

If not at place of death? Unknown

Former or usual residence 317 So. Bethel St.

19 PLACE OF BURIAL OR REMOVAL Evenangelick Church DATE OF BURIAL Jan 15, 1915

20 UNDERTAKER H. Sandertson ADDRESS 1701 E. Balto

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Imbition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 361 (43)
 County Balto
 Village or City Highlandtown 305 S 2nd St.; 41 Ward)
 2 FULL NAME Annice Schulz

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married
 (Write the word)

6 DATE OF BIRTH Sept 14, 1868
 (Month) (Day) (Year)

7 AGE 46 yrs. 4 mos. 10 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work. Housework
 (b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9 BIRTHPLACE (State or country) Balto.

10 NAME OF FATHER Geo. Myers

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Veronica Bierage

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Veronica Stern

(Address) 305 S 2nd St.

15 Filed Jan 26, 1915 W. E. McClanahan
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 24, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1914 to Jan 24, 1915

that I last saw her alive on Jan 24, 1915

and that death occurred on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) X yrs. X mos. 7 ds.

Contributory Carcinoma breast
 Secondary

(Duration) 1 yrs. X mos. X ds.

(Signed) Jas. L. Truax, M. D.
Jan 28, 1915 (Address) 248 So. Blvd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oak Lawn DATE OF BURIAL Jan 27, 1915

20 UNDERTAKER Philip Herwig Orleans ADDRESS 3016

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicide, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 6 1916
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

362

County

Balto. Md.

(113)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

402

Village or City

St. Agnes' Hospital

(No.)

St.

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mrs. Martin Schwartz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6 DATE OF BIRTH

November 10, 1855

(Month)

(Day)

(Year)

7 AGE

60 yrs. 2 mos. 2 ds.

If LESS than 1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Germany

PARENTS

10 NAME OF FATHER

Do not know

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

A. Therner

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. A. Martin

(Address)

same add

15

Filed

Jan. 13, 1915 Henry H. Loos
Deputy Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 12, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 11, 1915 to Jan. 12, 1915

that I last saw him alive on Jan. 12, 1915

and that death occurred on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(Duration) yrs. mos. ds.

Contributory

Secondary

Asphyxial Choke

(Duration) yrs. mos. ds.

(Signed)

James H. Kitzinger, M. D.

Jan. 13, 1915 (Address) St. Agnes' Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence 214 Strickland St.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Cem.

Jan. 15, 1915

20 UNDERTAKER

ADDRESS

Martin Fahey & Son.

666 M. Lafayette

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

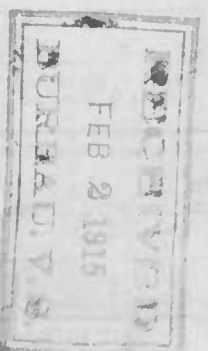
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Tropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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363
 1 PLACE OF DEATH *John I. Harrison*
 County *Baltimore* acting *Coroner* 91
 Village or City *Towson* (No. *76*) St. Ward
 2 FULL NAME *Herbert A. Scott*
 Registration Dist. No. *38*
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*
 6 DATE OF BIRTH *Oct 20, 1914*
 (Month) (Day) (Year)
 7 AGE *3* yrs. *4* mos. *4* ds. IF LESS than 1 day, hrs. OR min.?
 8 OCCUPATION (a) Trade, profession, or particular kind of work *none*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 9 BIRTHPLACE (State or country) *Towson Md*

PARENTS

10 NAME OF FATHER *Harrison Scott*
 11 BIRTHPLACE OF FATHER (State or country) *Baltimore Md*
 12 MAIDEN NAME OF MOTHER *Edith Langdon*
 13 BIRTHPLACE OF MOTHER (State or country) *Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Edith Langdon*
 (Address) *Towson Md*

15 Filed *Jan 20, 1915* *Claude S. Harrison*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 24, 1915*
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *191* to *191*,
 that I last saw him alive on *at all*, 191

and that death occurred on the date stated above, at *11 A.* m.

The CAUSE OF DEATH* was as follows:

Called after tabe died.
Broncho Pneumonia
 (Duration) yrs. mos. *1* ds.

Contributory *Stitis Media*
 Secondary
 (Duration) yrs. mos. *7* ds.

(Signed) *Claude S. Harrison* Physician
Jan 25, 1915 (Address) *Towson Md*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Pleasant Rest. Cem.* DATE OF BURIAL *Jan 26, 1915*
 20 UNDERTAKER *John Barnes Jones* ADDRESS *Towson*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

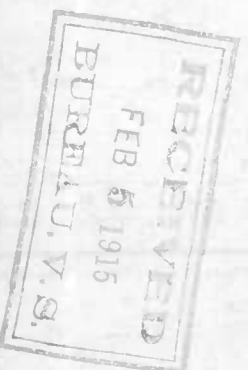
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Typhic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, STRENUOUS, or NONSTRENUOUS, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| 1 PLACE OF DEATH | | 364 | | STATE OF MARYLAND | |
|--|---|---|--|---|--|
| County <u>Baltimore</u> | | (157) | | CERTIFICATE OF DEATH 41 | |
| Village or City <u>Highlandtown</u> | | (No. <u>8919</u>) | | Registration Dist. No. <u>12</u> | |
| 2 FULL NAME <u>Robert 4th Mr. Edgar J. Scott</u> | | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word) | | | |
| 6 DATE OF BIRTH <u>Jan 22, 1915</u> (Month) (Day) (Year) | | | | | |
| 7 AGE _____ yrs. _____ mos. _____ ds. OR LESS than 1 day, ____ hrs. OR ____ min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment to which employed (or employer) _____ | | | | | |
| 9 BIRTHPLACE (State or country) <u>Ind</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>John Scott</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Mary Baird</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Elizabeth Baird</u> (Address) <u>3231 Edmond St.</u> | | | | | |
| 15 FILED <u>Jan 23 1915</u> <u>W. E. McClanahan</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>Jan 22, 1915</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>on Jan 22, 1915</u> to <u>Jan 22, 1915</u> that I last saw him alive on <u>Jan 22, 1915</u> and that death occurred on the date stated above, at <u>4 a.m.</u> The CAUSE OF DEATH* was as follows: <u>Premature Birth</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>Unknown</u> Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>M. J. McAvoy</u> , M. D. <u>Jan 22, 1915</u> (Address) <u>839 S. Ellwood St.</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Sacred Heart Ch.</u> DATE OF BURIAL <u>Jan 23, 1915</u> | | | | | |
| 20 UNDERTAKER <u>Lilly and Zile</u> ADDRESS <u>4038 W. 11th St.</u> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

365

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 47

County BaltimoreVillage or City Bay View Asylum (No. CITY HOSPITAL St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Seymour

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|----------------------|---------------------------------|--|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> |
|----------------------|---------------------------------|--|

6 DATE OF BIRTH 1. 849.
(Month) (Day) (Year)7 AGE 66 yrs. 66 mos. 66 ds. 66 OR 66 min. ?
It LESS than 1 day, 66 hrs.8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER William Seymour11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Dorothy Drury13 BIRTHPLACE OF MOTHER (State or country) Maryland14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records
(Address) Bay View15 Filed Jan 16, 1915 Myram Baer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 14th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from January 13th, 1915, to January 14th, 1915.that I last saw him alive on January 14th, 1915.and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
unknown
(Duration) yrs. mos. ds.Contributory Fistula in ano
Secondary unknown
(Duration) yrs. mos. ds.(Signed) H. C. Prince, M. D.
Jan. 15, 1915. (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence Unknown19 PLACE OF BURIAL OR REMOVAL Johns Hopkins Hospital DATE OF BURIAL Jan 16, 191520 UNDERTAKER H. L. Hawley ADDRESS 1109 N. Belmor

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

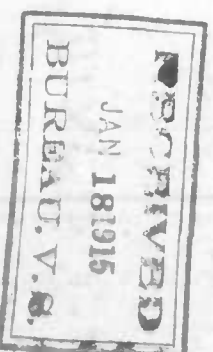
[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County BaltimoreVillage or City Bay View Asylum.

366

25

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41(No. CITY HOSPITAL St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jennie Shott

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|------------------------|---------------------------------|---|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u> |
|------------------------|---------------------------------|---|

6 DATE OF BIRTH
1871
(Month) (Day) (Year)7 AGE
44 yrs. 44 mos. 44 ds. OR 1 day, 1 hr. 1 min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE
(State or country) Maryland

| | |
|---------|---|
| PARENTS | 10 NAME OF FATHER <u>Joseph Cvach</u> |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Europe</u> |
| | 12 MAIDEN NAME OF MOTHER <u>Annie (Unknown)</u> |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Europe</u> |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records
(Address) Bay View15 Filed Jan 18, 1915 Mrs. M. B. Carr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 17th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from January 4th 1915, to January 17th 1915.that I last saw her alive on January 17th, 1915.and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

My catie infection of L. Lung(Duration) about 1 yr. yrs. 1 mos. 1 ds.Contributory Secondary hemorrhage
Secondary few minute(Duration) few minute yrs. 1 mos. 1 ds.(Signed) W. Houston Paulson, M. D.Jan. 18, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 13 yrs. 13 mos. 13 ds. In the State 13 yrs. 13 mos. 13 ds.

Where was disease contracted, If not at place of death?

Former or usual residence 827 N. Durham St.19 PLACE OF BURIAL OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Jan 20, 191520 UNDERTAKER J. Cvach ADDRESS 1902 Ashland

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faithfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Baltimore

Village or City Bay View Asylum

(No. 28)

Registration Dist. No. 41

St. MUNICIPAL TUBERCULOSIS HOSP. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Nannie Friems

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH

1. 891
(Month) (Day) (Year)

7 AGE

23 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Virginia

PARENTS

10 NAME OF FATHER

Seymour Nash

11 BIRTHPLACE OF FATHER (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Hallie Godsey

13 BIRTHPLACE OF MOTHER (State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Bay View

15

Filed

Jan 11, 1915

Mrs. M. B. Bae

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 11, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec. 1, 1914 to Jan. 11, 1915
that I last saw her alive on Jan. 10, 1915

and that death occurred on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 5 yrs.

Contributory
Secondary

Syphilis

(Duration) 10 yrs.

(Signed) H. F. Callahan, M. D.

Jan 11, 1915 (Address) City St. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 11 mos. 11 ds. In the State Virginia

Where was disease contracted, Unknown

Former or usual residence 767 George St.

19 PLACE OF BURIAL OR REMOVAL

Richmond, Va

DATE OF BURIAL

Jan 14, 1915

20 UNDERTAKER

LeRoy B. Pye

ADDRESS

102 E. Mulberry St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

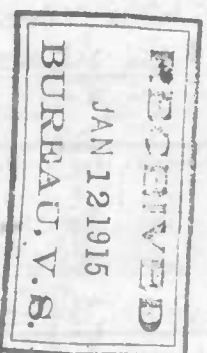
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

368

County

Balto

(S)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41

Village or City

Colgate

(No. _____)

St.; _____

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Samuel Sibley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

1 2, 1915
(Month) (Day) (Year)

7 AGE

If LESS than
1 day, ____ hrs.
____ yrs. ____ mos. ____ ds. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Maryland

10 NAME OF FATHER

John Sibley

11 BIRTHPLACE OF FATHER
(State or country)

Va

12 MAIDEN NAME OF MOTHER

Sadie Thomas

13 BIRTHPLACE OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sara James

(Address)

2036 Keyser

15

Filed

Jan. 5, 1915 W. E. McClanahan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 2, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

_____, 191____, to _____, 191____.

that I last saw him alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

A. S. Warner

M. D.

Jan. 5, 1915 (Address) Leonard

*State the DISSEMINATING DEATH, or, if deaths from VIOLENT CAUSES, state (1) MANNER OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Green Willow

DATE OF BURIAL

Jan 5, 1915

20 UNDERTAKER

Peter Nicolaus

ADDRESS

2046 Eastern Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* or *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County BaltimoreVillage or City Mt Hope(No. 68)St. Mt Hope Retreat

Ward

Registration Dist. No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Smeltzer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Nov 26, 1877
(Month) (Day) (Year)

7 AGE 37 yrs. 10 mos. 0 ds. OR 38 yrs. 0 mos. 0 ds. It LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

PARENTS
10 NAME OF FATHER John Smeltzer
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER Margaret Ertl
13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Records of Mt Hope Retreat
(Address) Mt Hope Ma

15 Filed Jan 27, 1915 Wm G. Quinn
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 26, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 17 - 1909 (191), to Jan 26, 1915.

that I last saw him alive on Jan 26, 1915.

and that death occurred on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:
Melanchoia Chronic

abs (Duration) 6 yrs. 0 mos. 0 ds.

Contributory Ex. Meningitis (Post. Tubercular)
Secondary Epileptoid Convulsions

abs (Duration) 1 yrs. 0 mos. 0 ds.

(Signed) Frank J. Henshaw, M. D.

Jan 27, 1915 (Address) Mt Hope Retreat

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 6 yrs. 0 mos. 0 ds. In the Life time State Life time yrs. mos. ds.

Where was disease contracted, Baltimore Md.

If not at place of death?
Former or usual residence Baltimore Md.

19 PLACE OF BURIAL OR REMOVAL Mt Hope Retreat DATE OF BURIAL Jan 27, 1915

20 UNDERTAKER Christian Miller ADDRESS 333 York St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

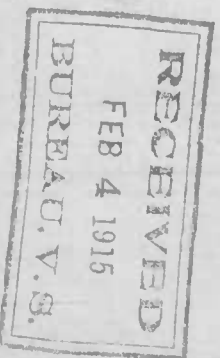
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| | | | | | |
|---|---------------------------------|---|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 370 <u>28</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Baltimore</u> (No. _____) | | St. _____ | | Registration Dist. No. <u>41</u> | |
| 2 FULL NAME <u>Philip Smick</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word) | | | |
| 6 DATE OF BIRTH _____, 18 <u>72</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>42</u> yrs. ____ mos. ____ ds. 11 LESS than 1 day, ____ hrs. OR ____ min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>State roadman</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | | | |
| PARENTS | | | | | |
| 10 NAME OF FATHER <u>unknown</u> | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) " | | | | | |
| 12 MAIDEN NAME OF MOTHER " | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) " | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hospital Records</u> (Address) <u>Bay View</u> | | | | | |
| 15 Filed <u>Jan 3rd 1915</u> <u>Miriam Bae</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>Jan. 3</u> , 191 <u>5</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 27</u> , 191 <u>4</u> , to <u>Jan 3</u> , 191 <u>5</u> , that I last saw him alive on <u>Jan 3</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>12 noon</u> . The CAUSE OF DEATH* was as follows: <u>Phthisis pulmonalis</u> (Duration) <u>1 yr.</u> ____ mos. ____ ds. Contributory <u>Tubercular enteritis</u> Secondary (Duration) <u>unknown</u> yrs. ____ mos. ____ ds. (Signed) <u>F. F. Callahan</u> , M. D. <u>Jan 3</u> , 191 <u>4</u> (Address) <u>City St Hospital</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State <u>42</u> yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? <u>unknown</u> Former or usual residence <u>1801 N. Chapel St</u> | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Balto. Cemetery</u> DATE OF BURIAL <u>Jan 6th</u> , 191 <u>5</u> | | | | | |
| 20 UNDERTAKER <u>Ed. Tanning</u> ADDRESS <u>Laf. + Wash.</u> | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

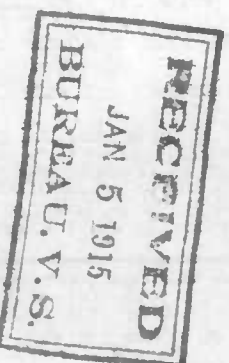
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. If or many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

371

County Baltimore

Village or City

Bay View Asylum

(No. _____)

Registration Dist. No. 41STATE OF MARYLAND
CERTIFICATE OF DEATH

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDDED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

Jan. 9, 1875
(Month) (Day) (Year)

7 AGE

40 yrs. mos. ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Worcester, Mass.

PARENTS

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER
(State or country)"

12 MAIDEN NAME OF MOTHER

"13 BIRTHPLACE OF MOTHER
(State or country)"

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

Bay View

15

Filed Jan 21, 1915Minna Brew

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 9, 1915, to Jan. 18, 1915
that I last saw him alive on Jan. 18, 1915and that death occurred on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Pathologic PulveralsContributory
SecondarySubacute meningitis
(Duration) 7 yrs. 8 mos. 2 ds.(Duration) yrs. mos. 9 ds.(Signed) J. J. Callahan, M. D.
Jan. 18, 1915 (Address) City & Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 9 ds. In the State Wife yrs. mos. ds.Where was disease contracted, UnknownIf not at place of death? Former or usual residence 302 N. Patterson Park Ave.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred HeartJan 21, 1915

20 UNDERTAKER

ADDRESS

Hilly-Zeiler403 S. Wolfe

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | |
|--|---------------------------------|--|--|
| 1 PLACE OF DEATH <u>Baltimore</u> 372 | | STATE OF MARYLAND | |
| County <u>Baltimore</u> (62) | | CERTIFICATE OF DEATH | |
| Village or City <u>Sparks St.</u> (No. <u>1</u> St. <u>H.</u>) | | Registration Dist. No. <u>44</u> | |
| 2 FULL NAME <u>John Smith</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u> | |
| 6 DATE OF BIRTH <u>June 29</u> , 184 <u>7</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>68</u> yrs. <u>6</u> mos. <u>9</u> ds. | | If LESS than 1 day.....hrs. OR.....min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer.</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>General Laborer</u> | | | |
| 9 BIRTHPLACE (State or country) <u>Germany</u> | | | |
| PARENTS | | | |
| 10 NAME OF FATHER <u>Unknown</u> | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> | | | |
| 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Margaret Smith</u> (Address) <u>1151 Sparks St.</u> | | | |
| 15 FILED <u>Jan 9th</u> , 191 <u>5</u> <u>G. L. McCormick</u> M.D. REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>Jan. 8th</u> , 191 <u>5</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 1st</u> , 191 <u>3</u> , to <u>Jan 8th</u> , 191 <u>5</u> , that I last saw him alive on <u>Jan 7th</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>2 a.</u> m. The CAUSE OF DEATH * was as follows: <u>Tuberc Dorsalis</u> (Duration) <u>2</u> yrs. mos. ds. Contributory <u>Apoplexy</u> Secondary (Duration) yrs. mos. ds. (Signed) <u>G. L. McCormick</u> , M. D. <u>Jan 9</u> , 191 <u>5</u> (Address) <u>Sparks St.</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence 19 PLACE OF BURIAL OR REMOVAL <u>Wat. Carmel Cem.</u> DATE OF BURIAL <u>Jan 10</u> , 191 <u>5</u> 20 UNDERTAKER <u>Joseph Herr</u> ADDRESS <u>Sparks St. Balto.</u> | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

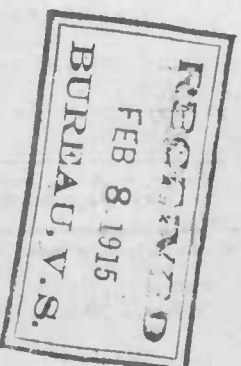
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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¹ PLACE OF DEATH

373

County Baltimore

(15-2)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 43

Village or City St. Denis

(No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME

Catherine Smithson

PERSONAL AND STATISTICAL PARTICULARS

³ SEX

female

⁴ COLOR OR RACE

white

⁵ SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

single

⁶ DATE OF BIRTH

Jan 28, 1915
(Month) (Day) (Year)

⁷ AGE

lived 10 min. day _____ hrs. _____
yrs. _____ mos. _____ ds. OR 10 min. ?

⁸ OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE

(State or country)

St. Denis
Baltimore

PARENTS

¹⁰ NAME OF FATHER

Charles F. Smithson

¹¹ BIRTHPLACE OF FATHER

(State or country)

Maryland

¹² MAIDEN NAME OF MOTHER

May Catherine Bush

¹³ BIRTHPLACE OF MOTHER

(State or country)

Maryland

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

May C. Smithson

(Address)

444 B & E Rd

¹⁵

Filed Jan 29, 1915 J. H. Rule
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH

Jan 28, 1915
(Month) (Day) (Year)

¹⁷

I HEREBY CERTIFY, That I attended deceased from

Jan 28, 1915, to Jan 28, 1915,

that I last saw her alive on Jan 28, 1915

and that death occurred on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH* was as follows:

Difficult labor

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Arthur Williams, M. D.

Jan 29, 1915 (Address) Elk Ridge Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Augustine's E. & W. of Jan 29, 1915

²⁰ UNDERTAKER

ADDRESS

F. Gill Elk Ridge Rd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

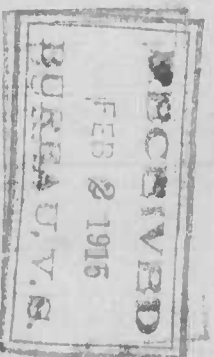
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH

County BaltimoreVillage or City Baltimore(No. 28)Registration Dist. No. 41St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles Summerfield

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)widowed

6 DATE OF BIRTH

Jan 20, 1850
(Month) (Day) (Year)

7 AGE

75 yrs. 0 mos. 0 ds. If LESS than 1 day, 0 hrs. 0 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Gen'l Balancer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Germany

PARENTS

10 NAME OF FATHER

George Summerfield11 BIRTHPLACE OF FATHER
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Marie Goldman13 BIRTHPLACE OF MOTHER
(State or country)Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles F. Evans (M.D.)

(Address)

118 W. Mt. Royal Ave.

15

Filed Jan 20, 1915Marion Burr
REGISTRARSTATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 20, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug 3, 1914 to Jan 20, 1915that I last saw him alive on Jan 19, 1915and that death occurred on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis(Duration) 2 yrs. 7 mos. 0 ds.Contributory
Secondary(Duration) 0 yrs. 0 mos. 0 ds.(Signed) F. J. Callahan, M. D.Jan 20, 1915. (Address) City H Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 5 yrs. 17 mos. 17 ds. In the 0 yrs. 0 mos. 0 ds.Where was disease contracted, UnknownFormer or usual residence Union Ave; Marvel Park

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred HeartJan 20, 1915

20 UNDERTAKER

ADDRESS

Willie - Zulu1038 W. 1st

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

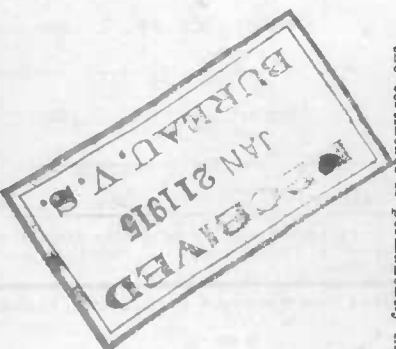
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or DOMESTIC, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 375
 County Baltimore (92) 17^W
 State of Maryland
 Certificate of Death
 Registration Dist. No. 32
 Village or City Arlington (No. 5741, Park Heights St.; Ward)
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Wilbur B. Stewart

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH Sept. 6, 1856
 (Month) (Day) (Year)

7 AGE 58 yrs. 3 mos. 28 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Merchant
 (b) General nature of industry, business, or establishment in which employed (or employer) (Grocery store)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Jos. B. Stewart

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachael Sparks

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Stewart

(Address) 5141 Park Heights Ave

15 Filed Jan 15, 1915 Harry G. Naylor

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 3, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1914, to July 3, 1915.

that I last saw him alive on July 2, 1915.

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia - Traumatic
Acute Fall - P. M. S. S.
 (Duration) 7 yrs. 0 mos. 3 ds.

Contributory Traumatic Secondary fall of 16

5 clinics (Duration) 7 yrs. 0 mos. 3 ds.

(Signed) Charles F. Hies, M. D.

, 191 (Address) Arlington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 7 yrs. 0 mos. 3 ds. In the State 7 yrs. 0 mos. 3 ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

London Park Jan 5, 1915

20 UNDERTAKER ADDRESS

W. J. Knepper North & Penn

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

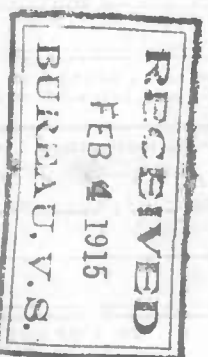
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 376
County Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41

Village or City Bay View Asylum for Insane Hospital St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Henry Strodtman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH ? (Month) (Day) (Year)

7 AGE 73 yrs. mos. ds. OR 1 day, hrs. min. ? If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work not known
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address) Bay View

15 Filed Jan 24, 1915 Miriam Baer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 23, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1914 to Jan 23, 1915.

that I last saw him alive on Jan 23, 1915

and that death occurred on the date stated above, at 6:40 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) ? yrs. mos. ds.

Contributory Failing Compensation
Secondary

(Duration) ? yrs. mos. ds.

(Signed) Henry E. Austin, M. D.

191 (Address) Bay View Hoof

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 3 mos. 1 ds. In the ? State ? yrs. ? mos. ? ds.

Where was disease contracted, ?
If not at place of death?

Former or usual residence 1105 Shepard St

19 PLACE OF BURIAL OR REMOVAL London Park Cem DATE OF BURIAL Jan 26, 1915

20 UNDERTAKER E. Haele ADDRESS 115 E. West

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faithfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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377

1 PLACE OF DEATH

County Baltimore

169

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 37Village or City Ashtland

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Seth Talbott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widower
(Write the word)

6 DATE OF BIRTH unknown

(Month) (Day) (Year)

7 AGE about 63 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Wm Talbott

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (State or country)

unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herbert Talbott

(Address)

Woodberry Ave

15

Filed Jan 1, 1915 B333 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 1, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 191....., to 191.....

that I last saw him alive on 191.....

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

accidental drowning in the Western Run at Ashtland Baltimore County

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Daniel M Wilhelm J P, M. D.
Jan 1, 1915 (Address) Pockeysville md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balto MdJan 2, 1915

20 UNDERTAKER

ADDRESS

Ed Roy Stupples8400 6th St Balto

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

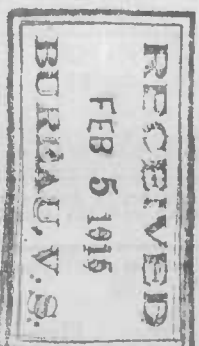
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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378

1 PLACE OF DEATH

County

*Baltimore*STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highlandtown 3801 Foster ave

(No.)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Talkemeier

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Unknown

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

SEPARATED

(Write the word)

Embryo

6 DATE OF BIRTH

Jan 17, 1915
(Month) (Day) (Year)

7 AGE

4 month Embryo
yrs. mos. ds. OR min. ?It LESS than
1 day.....hrs.
OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Edward Talkemeier

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Lillian Carbis

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lillian Carbis

(Address)

3801 Foster ave

15

Filed

Jan 25, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

Still Born Jan 17, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw h..... alive on....., 191.....

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

4 month Still Born Embryo
(Duration).....yrs.....mos.....ds.Contributory
Secondary(Signed) *J. B. Titlow*, M. D.
Jan 17, 1915 (Address) *303 N. O'Donnell*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Johns Hopkins Hosp.
191.....

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tubercles of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicaemia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

This certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 6 1915
BUREAU.

RECEIVED
JAN 22 1915
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

380

County BaltimoreVillage or City Met Washington (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 32

2 FULL NAME

Taylor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Unknown

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)

6 DATE OF BIRTH

1 11, 1915
(Month) (Day) (Year)

7 AGE

6 yrs. 6 mos. 10 hrs. 45 min. ?
If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Ind

PARENTS

10 NAME OF FATHER

Thomas Taylor

11 BIRTHPLACE OF FATHER (State or country)

England

12 MAIDEN NAME OF MOTHER

Alma Coleman

13 BIRTHPLACE OF MOTHER (State or country)

Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15

Filed Jan-19, 1915 Henry A. Taylor
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 11, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1915, to Jan 11, 1915.

that I last saw him alive on _____, 1915.

and that death occurred on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Unknown - May be due to
Angemic Condition of mother
History Negative

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. H. Beeton, M. D.

1-16, 1915 (Address) Met Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

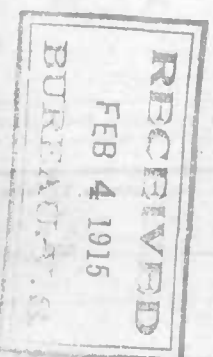
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

381

County

Baltimore

(92)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

32

Village or City

Chattanooga

(No.)

Md

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Annie Taylor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

widow

6 DATE OF BIRTH

unknown, 1

(Month)

(Day)

(Year)

7 AGE

55

yrs.

mos.

ds.

It LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

washing

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Calvert Co Md

PARENTS

10 NAME OF FATHER

Anthony Howard

11 BIRTHPLACE OF FATHER

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER

(State or country)

unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie Price

(Address)

Garrison Md

15

Filed

2/1/1915

1915

Henry L. Mayhew

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

any

30

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 29, 1915

to July 30, 1915

that I last saw her alive on

July 30, 1915

and that death occurred on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobor Pneumonia

(Duration)

yrs.

mos.

2 ds.

Contributory
Secondary

Valvular disease of heart.

Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

W. E. Mayhew

M. D.

2-2

1915

(Address)

Petersburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place

of death

In the

State

yrs.

mos.

ds.

yrs.

mos.

ds.

Where was disease contracted,
If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St John's Cemetery

Feb 3, 1915

20 UNDERTAKER

Calvert Co Md

ADDRESS

J F Elio

Rustington

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

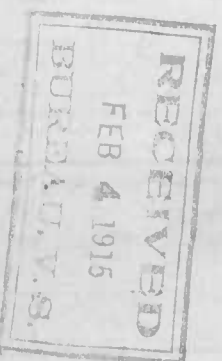
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| 1 PLACE OF DEATH | | | 382 | | 28 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|--|---------------------------------|--|----------------------------------|--|---|--|---|--|
| County <u>Baltimore</u> | | | Registration Dist. No. <u>30</u> | | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| Village or City <u>Catonsville Spring Groves</u> (No. <u>4</u> Ward) | | | | | | | | |
| 2 FULL NAME <u>Elice Taylor</u> | | | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | MEDICAL CERTIFICATE OF DEATH | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u> | | | 16 DATE OF DEATH <u>Jan 23rd</u> , 191 <u>5</u> (Month) (Day) (Year) | | | |
| 6 DATE OF BIRTH <u>April 23rd</u> , 18 <u>85</u> (Month) (Day) (Year) | | 7 AGE <u>29</u> yrs. <u>8</u> mos. <u>25</u> ds. If LESS than 1 day.....hrs. OR.....min.? | | | 17 I HEREBY CERTIFY, That I attended deceased from <u>April 1st</u> , 191 <u>2</u> to <u>Jan 23rd</u> , 191 <u>5</u> that I last saw him alive on <u>Jan 23rd</u> , 191 <u>5</u> and that death occurred on the date stated above, at <u>8 P</u> M. The CAUSE OF DEATH* was as follows: | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Carpenter</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | Pulmonary Tuberculosis (Duration) yrs. <u>2</u> mos. <u>14</u> ds. Contributory (Secondary) <u>Pulmonary Hemorrhage</u> (Duration) yrs. <u>1</u> mos. <u>14</u> ds. (Signed) <u>Percy Wade</u> , M. D. <u>Jan 24</u> , 191 <u>5</u> (Address) <u>Catonsville, Md</u> | | | |
| PARENTS | | 10 NAME OF FATHER <u>H. Harrison Taylor</u> | | | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> | | 12 MAIDEN NAME OF MOTHER <u>Annie F. Blake</u> | | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>2</u> yrs. <u>10</u> mos. <u>17</u> ds. In the State..... yrs. mos. ds. Where was disease contracted, if not at place of death? <u>Somerset Co. Md</u> Former or usual residence <u>Somerset Co. Md</u> | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> | | 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Elice Taylor</u> (Address) <u>108 E 25th St. Balto</u> | | | 19 PLACE OF BURIAL OR REMOVAL <u>Crisfield Md</u> DATE OF BURIAL <u>Jan 25th</u> , 191 <u>5</u> | | | |
| 15 Filed <u>Jan 24</u> , 191 <u>5</u> <u>Manhall B Wirt</u> REGISTRAR | | 20 UNDERTAKER <u>F. B. Stewart</u> ADDRESS <u>Med's</u> | | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

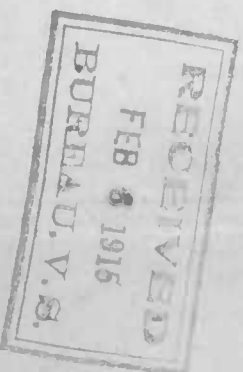
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Bay View Asylum(No. 20) CITY HOSPITAL

St. _____ Ward _____

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]2 FULL NAME John Taylor

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|----------------------|---------------------------------|--|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u> |
|----------------------|---------------------------------|--|

6 DATE OF BIRTH

1.840.
(Month) (Day) (Year)

7 AGE

75 yrs. 0 mos. 0 ds. OR 0 min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work Tailor

(b) General nature of industry,
business, or establishment in
which employed (or employer) _____

9 BIRTHPLACE
(State or country)England

PARENTS

10 NAME OF
FATHERUnobtainable11 BIRTHPLACE
OF FATHER
(State or country) "12 MAIDEN NAME
OF MOTHER "13 BIRTHPLACE
OF MOTHER
(State or country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15

Filed Oct 1st, 1915Mariam Barr

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 30th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
January 29th 1915, to January 30th, 1915.that I last saw him alive on January 30th, 1915.and that death occurred on the date stated above, at 12.15A m.

The CAUSE OF DEATH* was as follows:

Streptococcic Septicemia(Duration) 1 yrs. 0 mos. 0 ds.Contributory
SecondaryCellulitis of R. Arm(Duration) 7 yrs. 0 mos. 0 ds.(Signed) W. Houston HoustonM. D.Jan. 30th 1915 (Address) CITY HOSPITAL*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDEN-
TAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)At place
of death 1 yrs. 0 mos. 0 ds. In the
State 1 yrs. 0 mos. 0 ds.Where was disease contracted,
if not at place of death?Former or
usual residence 112 N. Pine St.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balto. Cemetery Oct 1st, 1915

20 UNDERTAKER

ADDRESS

W. Maurice Houston 230 N. Greene
St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

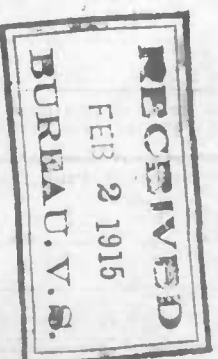
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

384

County Baltimore

(64)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Catonville (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Elizabeth Temmink

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

Oct. 15, 1849
(Month) (Day) (Year)

7 AGE

64 yrs. 3 mos. 14 ds.
If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Richard J. Temmink11 BIRTHPLACE OF FATHER
(State or country)Holland

12 MAIDEN NAME OF MOTHER

Mary C. Havink13 BIRTHPLACE OF MOTHER
(State or country)Holland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Temmink

(Address)

Ellicott City

15

Filed Jan 29, 1915 Marshall B. West
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 29, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 21, 1915 to Jan 29, 1915
that I last saw her alive on Jan 28, 1915and that death occurred on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia(Duration) _____ yrs. 8 mos. 8 ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Marshall B. West

M. D.

Jan 29, 1915 (Address) Catonville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

New Cathedral Cemetery

DATE OF BURIAL

Feb. 1, 1915

20 UNDERTAKER

S. Hillinger Son

ADDRESS

Ellicott City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

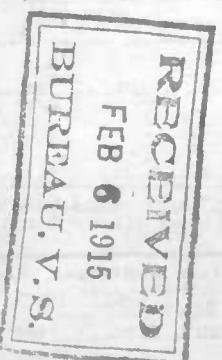
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Conventional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremula," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

385

County Balto.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 40Village or City Hyde Ind. (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mr. Nellie P. Temple

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH July 18, 1857
(Month) (Day) (Year)7 AGE 55 yrs. 6 mos. 6 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto. Co. Md.10 NAME OF FATHER Parker Magness11 BIRTHPLACE OF FATHER (State or country) Balto Co. Md.12 MAIDEN NAME OF MOTHER Mary Martin13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Temple(Address) Hyde Ind.15 Filed Jan 25, 1915 by J. F. H. Gossard

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 24, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Killed instantly by B + O
R. R. train at Bradshaw
9.30 A. M. Jan 24
1915 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. F. H. Gossard, M. D.
Jan 25, 1915 (Address) Fork Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fork Christian Cem Jan 26, 1915

20 UNDERTAKER ADDRESS

Lucas Art Co. & Son Fork Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

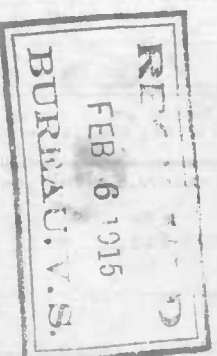
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County

Baltimore

386

(68)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 32

Village or City

Mt Hope

(No.)

Mt Hope Retreat

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James P. Thompson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Nov 17 1865, 1 (Month) (Day) (Year)

7 AGE

49 yrs. 10 mos. 8 ds. OR 50 yrs. 4 mos. 8 ds. It LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Lab over

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Balto and W. Va

PARENTS

10 NAME OF FATHER

Matthew Thompson

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Ann Deignan

13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Records of Mt Hope Retreat

(Address)

Mt Hope and

15

Filed Jan 25 1916 Wm. G. Queen

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 25 1915 (Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 3 1903, to Jan 25 1915that I last saw him alive on Jan 24 1915and that death occurred on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Mania - Terminal Dementia(Duration) 13 yrs. 0 mos. 0 ds.

Contributory

Secondary

Paralysis - Prognosis - abs(Duration) 10 yrs. 0 mos. 0 ds.(Signed) Frank J. Flannery, M. D.Jan 25 1915 (Address) Mt Hope Retreat

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 12 yrs. 0 mos. 0 ds. In the Don't Know State 0 yrs. 0 mos. 0 ds.Where was disease contracted, W. Va
If not at place of death?Former or usual residence Keiser W. Va

19 PLACE OF BURIAL OR REMOVAL

Keiser W. Va.

DATE OF BURIAL

January 26 1915

20 UNDERTAKER

Shaw & Howen C

ADDRESS

118 W North Ave.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

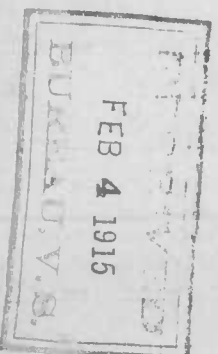
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

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| | | | | | |
|---|---|---|--|--|--|
| 1 PLACE OF DEATH County <u>Balto</u> | | 387 (157) | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Pleasant Hill</u> (No. <u>MD</u>) | | St. _____ Ward _____ | | Registration Dist. No. <u>33</u> | |
| 2 FULL NAME <u>Ernest J. D. Triplett</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | | | |
| 6 DATE OF BIRTH <u>Dec 4, 1898</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>16</u> yrs. <u>7</u> mos. <u>11</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Sahour</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Balto Co Md</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Ernest E. Triplett</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Balto Co Md</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Mary S. Greenham</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Balto Co Md</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary S. Triplett</u> (Address) <u>Chewings Mills Md</u> | | | | | |
| 15 Filed <u>Jan 6th</u> , 1915 <u>Ernest J. D. Triplett</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>January 4th</u> , 1915 (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h. _____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. | | | | | |
| The CAUSE OF DEATH* was as follows: <u>Suicide by hanging</u> | | | | | |
| (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| Contributory Secondary <u>John O'Brien, Jr. Acting Coroner, Md.</u> (Signed) _____, 1915 (Address) <u>Beltsville Md</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Deer Park Cemetery</u> | | | | DATE OF BURIAL <u>Jan 6th</u> , 1915 | |
| 20 UNDERTAKER <u>J. F. Elinor</u> | | | | ADDRESS <u>Riverdale Md</u> | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

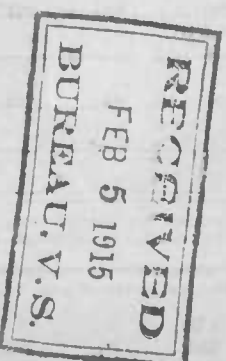
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH | | | 388 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|---|---|--|---------------------------------------|--|---|--|
| County <u>Baltimore</u> | | | (91) | | Registration Dist. No. <u>30</u> | |
| Village or City <u>Batonville</u> | | | (No. <u>The Richard Gundry Home</u>) | | Ward _____ | |
| 2 FULL NAME <u>David Halloway Twining</u> | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | |
| 3 SEX <u>male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u> | | | | |
| 6 DATE OF BIRTH _____, 18 <u>78</u> | | | | | | |
| (Month) (Day) (Year) | | | | | | |
| 7 AGE <u>87</u> yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. _____ min. ? | | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Farming</u> | | | | | | |
| 9 BIRTHPLACE (State or country) <u>Pa.</u> | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Isaac Twining</u> | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>unknown</u> | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Anne Hallowell</u> | | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>unknown</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | | |
| (Informant) <u>G. H. Hebert M.D.</u> | | | | | | |
| (Address) <u>The Richard Gundry Home</u> | | | | | | |
| 15 Filed <u>Jan 6</u> , 191 <u>5</u> <u>Marshall Burt</u> REGISTRAR | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | |
| 16 DATE OF DEATH <u>January 6</u> , 191 <u>5</u> | | | | | | |
| (Month) (Day) (Year) | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 13</u> , 190 <u>8</u> , to <u>Jan. 6</u> , 191 <u>5</u> , that I last saw him alive on <u>Jan 5</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>3:30 A. m.</u> | | | | | | |
| The CAUSE OF DEATH* was as follows: <u>Pneumo - pneumonia</u> | | | | | | |
| (Duration) yrs. _____ mos. <u>5</u> ds. | | | | | | |
| Contributory <u>Endocarditis with</u> | | | | | | |
| Secondary <u>Heart Insufficiency</u> (Duration) yrs. _____ mos. _____ ds. | | | | | | |
| (Signed) <u>Robert J. Gundry</u> , M. D. | | | | | | |
| _____, 191____ (Address) <u>Batonville</u> | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | | |
| At place of death <u>6</u> yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. | | | | | | |
| Where was disease contracted, If not at place of death? | | | | | | |
| Former or usual residence <u>Greenwood Baltimore, Md.</u> | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Fallston, Harford Co.</u> DATE OF BURIAL <u>Jan 9</u> , 191 <u>5</u> | | | | | | |
| 20 UNDERTAKER <u>B M Mitchell</u> ADDRESS <u>12016 Fayette</u> | | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

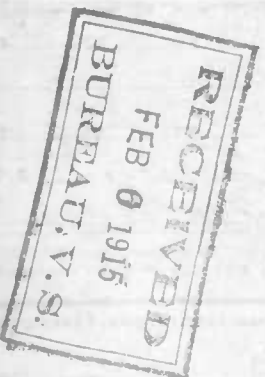
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 389
County Baltimore

Village or City Bay View Asylum (No. 28) St. MUNICIPAL TUBERCULOSIS HOSP. Ward

Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James Tynan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDDED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH

1878
(Month) (Day) (Year)

7 AGE

37 yrs. mos. ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work Drain - worker
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Phase Island

PARENTS

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (State or country)

"

12 MAIDEN NAME OF MOTHER

"

13 BIRTHPLACE OF MOTHER (State or country)

"

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address) Bay View

15

Filed Jan 5, 1915 Milam Baer

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 5, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1914, to Jan 5, 1915, that I last saw him alive on Jan 4, 1915

and that death occurred on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) 1 yrs. 5 mos. ds.

Contributory Intermittent meningitis
Secondary

(Duration) yrs. mos. ds.

(Signed) H. F. Callahan, M. D.
Jan 5, 1915 (Address) City & Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 12 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, 9 Ventnor
If not at place of death?

Former or usual residence 916 Ryan St

19 PLACE OF BURIAL OR REMOVAL St. Peters Cemetery DATE OF BURIAL Dec. 8th, 1915

20 UNDERTAKER John J. Cowan ADDRESS 901 Hollins

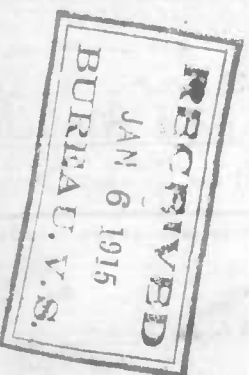
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

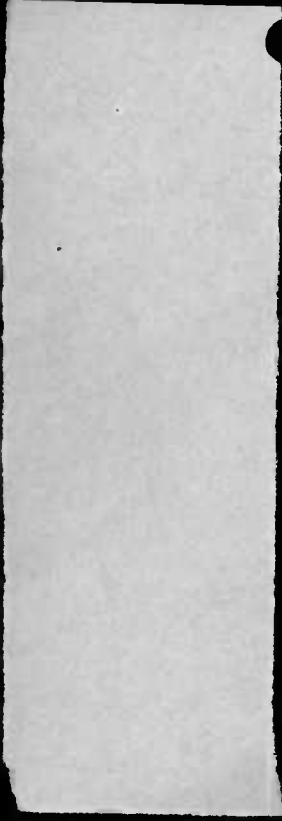
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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Typhoid cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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Carriakap on Pakpang?



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Baltimore

390

(92)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highlandtown

(No.

3229 Philadelphia Ave.

St.:

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Margaret Unkelbach

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Dec 3/1914

(Month)

(Day)

(Year)

7 AGE

yrs. 1 mos. 14 ds.

It LESS than
1 day.....hrs.
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

John Unkelbach

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Mecklen

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Unkelbach

(Address)

3229 Philadelphia Ave

15

Filed

Jan 18, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 17, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191

to

, 191

that I last saw him alive on

, 191

and that death occurred on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Probable Pneumonia

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

A. L. Warner, M. D.

Jan 18, 1915 (Address) Leesons

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Philadelphia County Jan 18, 1915

20 UNDERTAKER

ADDRESS

Christian Miller, 2334 Jefferson St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

391

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

40

Village or City

Londontown

(No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Unknown white male

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

Unknown

6 DATE OF BIRTH

Unknown

7 AGE

appears healthy

If LESS than
1 day.....hrs.
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Unknown

(b) General nature of Industry,
business, or establishment in
which employed (or employer)

Unknown

9 BIRTHPLACE

(State or country)

Unknown

PARENTS

10 NAME OF
FATHER

Unknown

11 BIRTHPLACE
OF FATHER
(State or country)

Unknown

12 MAIDEN NAME
OF MOTHER

Unknown

13 BIRTHPLACE
OF MOTHER
(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. F. A. Gorsuch

(Address)

Tolli md

15

Filed

Jan 17, 1915 A. F. A. Gorsuch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1780
suffered 5-6 weeks
Jan 17, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

never was found dead -
191 to 191

that I last saw h... alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

apparently as he was found
dead - in an accident
house at Londontown
on Jan 17, 1915 (Duration) yrs. mos. ds.

Contributory
Secondary

Empowered 5 years
duration 400 yrs. mos. ds.

(Signed)

A. F. A. Gorsuch, M. D.

Jan 17, 1915 (Address) Tolli md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salem M. E. Conn Jan 19, 1915

20 UNDERTAKER

ADDRESS

D. Davidson Bradshaw

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

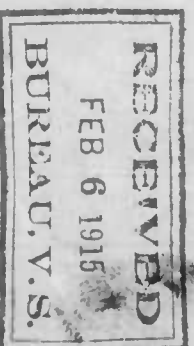
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tranition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*" etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

392

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty BaltimoreRegistration Dist. No. 41Village or City Bay View Asylum(No. 72-4) CITY HOSPITAL

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George E. Van Rossen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 1. 8. 47
(Month) (Day) (Year)

7 AGE 68 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Huckster
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Elijah Van Rossen

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Fanny Whitin

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15 Jan 28, 1915 Miriam Baer
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 27th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 8th, 1915 to January 27, 1915.

that I last saw him alive on January 27th, 1915

and that death occurred on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(Duration) unknown yrs. 0 mos. 0 ds.

Contributory Carcinoma of Prostate
Secondary

(Duration) unknown yrs. 0 mos. 0 ds.

(Signed) W. Houston Foulson, M. D.

Jan. 27th 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 9 yrs. 19 mos. 19 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 625 N. Wolfe St., City

19 PLACE OF BURIAL OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL Jan 28, 1915

20 UNDERTAKER H. Sanders & Sons ADDRESS 1701 E. Balt.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

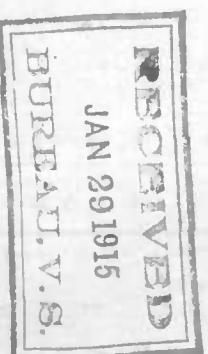
[Approved by U. S. Census and American Public Health Association.]¹

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. If or many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faithfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Baltimore

Village or City

(and)

Baltimore

(No.)

*3307**Mueller*

St.,

Ward)

Registration Dist. No.

41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lillian Vits

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Wh

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Feb. 7

(Month)

(Day)

1869
(Year)

7 AGE

45

yrs.

11

mos.

29

ds.

It LESS than
1 day.....hrs.
OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF FATHER

Beomaster

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

August Vits

(Address)

3307 Mueller St

15

Filed

Jan. 5

1915

W. E. M. Clonahan

REGISTERED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan.

(Month)

5

(Day)

1915
(Year)

17

HEREBY CERTIFY That I attended deceased from

Dec. 6

1915

to

Jan. 4

1915

that I last saw her alive on

Jan. 4

1915

and that death occurred on the date stated above, at *5 a* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration)

yrs.

2

mos.

ds.

Contributory (Secondary)

Inanition

(Duration)

yrs.

mos.

ds.

(Signed)

*Joseph Hamilton M. D.**Jan 6*

1915

(Address)

939 S. Chateaufort

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Mt. Carmel

DATE OF BURIAL

1/7

1915

20 UNDERTAKER

Wm Cook

ADDRESS

502 E. Hooker

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary). 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU, V. S.

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1 PLACE OF DEATH

County Baltimore

394

(120)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

Village or City Bay View Asylum (No. City Detention Hospital, for Ward)
Insane.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Frank Vopalecky

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 1.863
(Month) (Day) (Year)

7 AGE 52 yrs. 52 mos. 52 ds. OR 1 day, 52 hrs. 52 min. ?
IF LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Bohemia

PARENTS
10 NAME OF FATHER ?
11 BIRTHPLACE OF FATHER (State or country) Bohemia
12 MAIDEN NAME OF MOTHER ?
13 BIRTHPLACE OF MOTHER (State or country) Bohemia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Vopalecky(Address) 923 N. Wolfe St.

15 Filled Jan 26, 1915 Miriam Baer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 25th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 11th, 1915, to January 25th, 1915.

that I last saw him alive on January 25th, 1915.

and that death occurred on the date stated above, at 8.45 P.m.

The CAUSE OF DEATH* was as follows:

Uraemia and cerebral haemorrhage

(Duration) yrs. mos. ds.

Contributory Chr. interstitial nephritis
Secondary

(Duration) yrs. mos. ds.

(Signed) Philip Pearlstein, M. D.
Jan 25, 1915 (Address) City Detention Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 14 ds. In the State 35 yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence 923 N. Wolfe St.

19 PLACE OF BURIAL OR REMOVAL Holy Redeemer Ch. DATE OF BURIAL Jan 28, 1915

20 UNDERTAKER Frank Devoach ADDRESS 1904 Goshland Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Baltimore

Village or City Randallstown (No. _____, St.; _____ Ward)

2 FULL NAME Baby Walbeck

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 1 26 1915
(Month) (Day) (Year)

7 AGE _____ If LESS than 1 day, _____ hrs. _____ yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country)

Balt. Co.

PARENTS

10 NAME OF FATHER

W. C. Walbeck

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ada Griffin

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. C. Walbeck

(Address) Randallstown

15

Filed Jan. 26th 1915 Harry G. Naylor
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH 1 26 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Stillbirth from Jan 26 1915.

that I last saw him alive on Jan 10 30 a.m. 1915.

and that death occurred on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Protrusion of umbilical cord

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. E. Nichols M.D., M. D.

1-26 1915 (Address) Pikesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

David Ridge

DATE OF BURIAL

Jan 28th 1915

20 UNDERTAKER

C. H. Kraft

ADDRESS

Pikesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

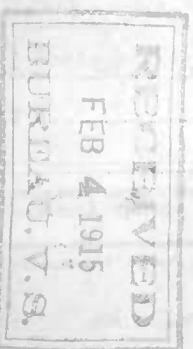
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accedent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on Nomenclature of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County BaltimoreBay View Asylum.Village or City (No) CITY HOSPITAL St. Ward Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Walker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 1-878
(Month) (Day) (Year)

7 AGE 37 yrs. mos. ds. OR min. ?
It LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Josh Walker

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eva (unknown)

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records(Address) Bay View

15 Filed Jan 18, 1915 Mrs. B. B. B.
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 15th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 12, 1915 to January 15th, 1915

that I last saw him alive on January 15th, 1915

and that death occurred on the date stated above, at 10.5 P.m.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis
(Duration) unknown yrs. mos. ds.

Contributory Myocardial Insufficiency
Secondary unknown yrs. mos. ds.

(Signed) U. C. Pincoffs, M. D.

Jan. 16, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? unknown

Former or usual residence (Unknown) Admitted from Mer-

19 PLACE OF BURIAL OR REMOVAL Johns Hopkins DATE OF BURIAL Jan 18, 1915

20 UNDERTAKER G. L. Hurley ADDRESS 1109 N. Belmor

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

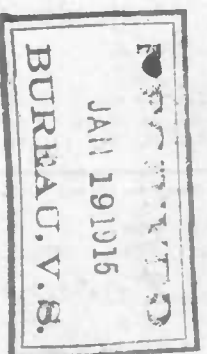
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recoiler wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

43

Village or City

Raspburg

(No. 5 Rockdale Ave

Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

Emma R. Walmsley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Jan 11, 1837

(Month)

(Day)

(Year)

7 AGE

57 yrs. 11 mos. 23 ds.

If less than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

At home

(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)

Md

10 NAME OF
FATHER

Jacob Barickman

11 BIRTHPLACE
OF FATHER
(State or country)

Md.

12 MAIDEN NAME
OF MOTHER

Elizabeth A. Olive

13 BIRTHPLACE
OF MOTHER
(State or country)

Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James G. Walmsley

(Address)

Raspburg

15

Filed

Jan. 5, 1915. W. F. Clayton

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

January 30, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 30, 1915, to Jan 30, 1915.
that I last saw him alive on Jan 30, 1915.

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Davis, M. D.

Jan 30, 1915 (Address) 2122 Cleburn St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDEN-
TAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

Baltimore

DATE OF BURIAL

Jan 6, 1915

20 UNDERTAKER

Fiskler Fiskler

ADDRESS

1739 E. Eager

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

V. S. No. 1.

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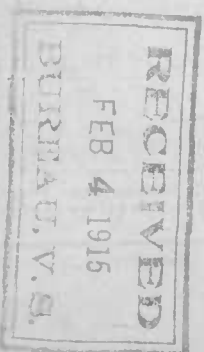
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—(coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

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1 PLACE OF DEATH Baltimore 398
 County Baltimore (67)
 Village or City Calverton Spring Grove P. O. (No. 67) St. 67 Ward 30
 Registration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Gray S. Melstrom

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)
 6 DATE OF BIRTH Aug 29th, 1869
 (Month) (Day) (Year)
 7 AGE 45 yrs. 4 mos. 18 ds. If LESS than 1 day, hrs. OR min. ?
 8 OCCUPATION (a) Trade, profession, or particular kind of work Merchant
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Israel S. Melstrom11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Annie Cade13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Melstrom(Address) 1006 N. Washington St.15 Filed Jan 17, 1915 Marshall B. West
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 16th, 1915
 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Nov 21st, 1909, to Jan 16th, 1915
 that I last saw him alive on Jan 16th, 1915and that death occurred on the date stated above, at 90 m,
 The CAUSE OF DEATH* was as follows:General Paresis
 (Duration) 4 yrs. mos. ds.

Contributory (Secondary)

(Signed) Percy Wade, M. D.
Jan 17th, 1915 (Address) Calonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. 10 mos. 2 ds. In the State 3 yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence Balto. Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross CemJan 20, 1915

20 UNDERTAKER

ADDRESS

Geo J. Kern.19148 Fayette St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative *zealfulness* of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—(coal mining, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 23 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 399

County Baltimore

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Baltimore (No. _____) St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ethel Ward

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE negro. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single.
(Write the word)

6 DATE OF BIRTH _____, 1889
(Month) (Day) (Year)

7 AGE 26 yrs. _____ mos. _____ ds. OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Gen'l Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Thomas Ward

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anne Hobson

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records
(Address) Bay View

15 Filed Jan 15, 1915 Miriam Baer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 14, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1914, to Jan. 14, 1915,
that I last saw him alive on Jan. 14, 1915,

and that death occurred on the date stated above, at 120 p m.
The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis.
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. F. Callahan, M. D.
Jan. 14, 1915 (Address) City & Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. 16 ds. In the State Unknown yrs. _____ mos. _____ ds.
Where was disease contracted, Unknown
If not at place of death?
Former or usual residence 2378 Bethel St.

19 PLACE OF BURIAL OR REMOVAL Johns Hopkins DATE OF BURIAL Jan 15, 1915

20 UNDERTAKER H. L. Hurley ADDRESS 7109 N. Hill

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| 1 PLACE OF DEATH | | | 400 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|---|--|--|-----------|--|---|--|
| County <u>Balto</u> | | | (120) | | Registration Dist. No. <u>80</u> | |
| Village or City <u>Woodlawn</u> (No. _____) | | | St. _____ | | Ward _____ | |
| 2 FULL NAME <u>Sophia Warden</u> | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u> | | 16 DATE OF DEATH <u>Jan 23rd</u> , 191 <u>5</u> (Month) (Day) (Year) | | |
| 6 DATE OF BIRTH <u>June 28th</u> , 18 <u>47</u> (Month) (Day) (Year) | | 17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 1st</u> , 191 <u>5</u> , to <u>Jan 2nd</u> , 191 <u>5</u> , that I last saw her alive on <u>Jan 2nd</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>8:30 p</u> m. | | | | |
| 7 AGE <u>67</u> yrs. <u>6</u> mos. <u>24</u> ds. | | The CAUSE OF DEATH* was as follows: <u>Industrial hepatitis -</u> <u>Acute Sclerosis</u> <u>Dilated Heart - Hemiplegia</u> (Duration) _____ yrs. _____ mos. _____ ds. | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | Contributory (Secondary) <u>Uremia</u> (Duration) _____ yrs. _____ mos. _____ ds. | | | | |
| 9 BIRTHPLACE (State or country) <u>Germany</u> | | (Signed) <u>A. C. Summitt</u> , M. D. <u>Jan 23rd</u> , 191 <u>5</u> (Address) <u>W. Franklin St.</u> | | | | |
| PARENTS | 10 NAME OF FATHER <u>Jacob Gilt</u> | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> | 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Catharine Kepler</u> | Where was disease contracted, If not at place of death? _____ | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u> | Former or usual residence _____ | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. Sophia Haener</u> (Address) <u>Woodlawn</u> | | | | | | |
| 15 Filed <u>Jan 23rd</u> , 191 <u>5</u> <u>A. C. Summitt</u> REGISTRAR | | 19 PLACE OF BURIAL OR REMOVAL <u>Lorraine Bern</u> | | DATE OF BURIAL <u>Jan 25</u> , 191 <u>5</u> | | |
| | | 20 UNDERTAKER <u>Geo. W. Little</u> | | ADDRESS <u>531</u> <u>W. Franklin St.</u> | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

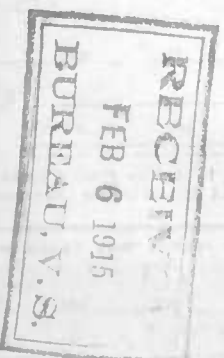
Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma. Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc. When a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Baltimore

401

79

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 37

Village or City Texas

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Nellie Warfield

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH 1860
(Month) (Day) (Year)

7 AGE 55
yrs. mos. ds. OR LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joshua T. Todd

(Address) Unionville

15 Filed Jan 3, 1915 A. F. Busey, M.D.
Dr. P. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 2, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
....., 191....., to 191.....

that I last saw him alive on 191.....

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Sudden) Probably Heart
Disease
(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.
(Signed) D. F. Busey, M. D.
Jan. 4, 1915 (Address) Texas, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Truro Hill DATE OF BURIAL Jan. 5, 1915

20 UNDERTAKER Edman Chapman ADDRESS Baltimore

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

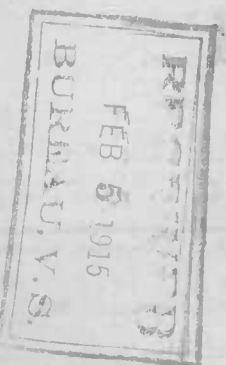
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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

402

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Bay View Asylum(No. CITY HOSPITALSt.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Cecelia Washington

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Unknown
(Write the word)

6 DATE OF BIRTH 1-8-67
(Month) (Day) (Year)

7 AGE 48 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Adam Edwards

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen Spence

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records
(Address) Bay View

15 Filed Jan 22, 1915 Marion Baer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 21st, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from November 18th, 1915 to January 21st, 1915

that I last saw her alive on January 21st, 1915

and that death occurred on the date stated above, at 4.30 P.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of the Ovary
(Duration) Unknown yrs. 0 mos. 0 ds.

Contributory
Secondary

(Signed) M. C. Prince, M. D.
Jan. 22, 1915 (Address) CITY HOSPITAL

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 2 yrs. 3 mos. 3 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, Unknown
If not at place of death?
Former or usual residence 505 W. Preston St.

19 PLACE OF BURIAL OR REMOVAL Laurel Cemetery DATE OF BURIAL Jan 23, 1915
20 UNDERTAKER Daniel Easton ADDRESS 916 Penna

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

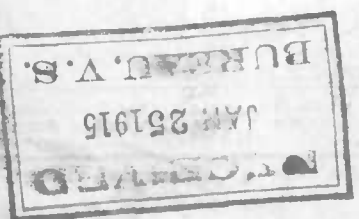
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use, of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scoble" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—decident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Balto

403

(119)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

411

Village or City

Highlandtown (No. 314 S East Ave)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

George Washington

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widower

6 DATE OF BIRTH

June 26, 1856
(Month) (Day) (Year)

7 AGE

58 yrs. 7 mos. 4 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Balto.

PARENTS

10 NAME OF FATHER

James H. Washington

11 BIRTHPLACE OF FATHER (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Julia A. Chapman

13 BIRTHPLACE OF MOTHER (State or country)

Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry H. Washington

(Address)

314 S East

15

Filed

Feb. 17, 1915 W. E. McClellan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 30, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

28, 1915, to 31, 1915,
that I last saw him alive on 30, 1915,
and that death occurred on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis(Duration) yrs. mos. ds. 3

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Clement, M. D.
Dr. J. H. Clement, 1915 (Address) 16 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount Cem Feb 2, 1915

20 UNDERTAKER

ADDRESS

Wm. C. Cook 502 E. North

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

g. S. M.
Statement of occupation—Precise statement of occupation is very important, so that the relative usefulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 6 1915

BUREAU, U. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Balto

Village or City Wetkin Ave + Linden Park (No. 15-4) St.; Ward)

2 FULL NAME William G. Watts

Registration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH October 6, 1834
(Month) (Day) (Year)

7 AGE 80 yrs. 26 mos. 26 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) md

PARENTS
10 NAME OF FATHER Rich Watts
11 BIRTHPLACE OF FATHER (State or country) md
12 MAIDEN NAME OF MOTHER Ruth Aruoa
13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rich Watts

(Address) Linden Park

15 Filed Jan 7, 1915 Marshall Blust

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 6, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h. _____ alive on _____, 191____,

and that death occurred on the date stated above, at 920 P. m.

The CAUSE OF DEATH* was as follows:

Wm S Watts had been complaining of a cold in his chest for 2 days and died before any doctor arrived.

(Duration) _____ yrs. _____ mos. 2 ds.

Contributory (Secondary) Infirmities of age

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Wm S. Hoffmann, Coroner, M. D.
Jan 6th, 1915 (Address) Catoonsville Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Mellinck Ave. Belridge DATE OF BURIAL Jan 8, 1915

20 UNDERTAKER Carroll Boon ADDRESS 174 E. N. Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or incurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 405
 County Baltimore (120)
 Village or City Catonsville (No. Spring Grove State Hospital)
 Registration Dist. No. 30
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Fannie Wells

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
 4 COLOR OR RACE White
 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July 8, 1847
 (Month) (Day) (Year)

7 AGE 67 yrs. 6 mos. 5 ds.
 If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work. none
 (b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Henry L. Hall

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah J. Little

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Jacob B. Wells

(Address) 1304 Linden Ave

15 Filed Jan 13, 1915 Marshall B. West
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 30

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 13, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1914 to Jan. 13, 1915

that I last saw her alive on Jan. 13, 1915

and that death occurred on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Bright's Disease
 (Duration) 1 yrs. 0 mos. 0 ds.

Contributory General Anasarca
 Secondary (Duration) 1 yrs. 0 mos. 0 ds.

(Signed) J. Percival Wade, M. D.
Jan. 13, 1915 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. 3 mos. 3 ds. In the 67 yrs. 6 mos. 5 ds.

Where was disease contracted, Baltimore Md

If not at place of death? Former or usual residence 1304 Linden Ave

19 PLACE OF BURIAL OR REMOVAL Mount Olivet DATE OF BURIAL Jan. 16, 1915

20 UNDERTAKER E. M. Mitchell ADDRESS 120 W. Fayette

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

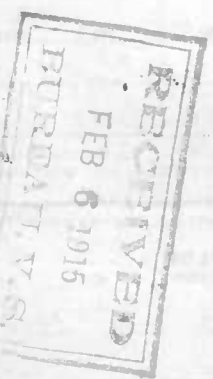
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverter wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 44PLACE OF DEATH
County BaltimoreVillage or City St Helena (No. _____, St.; Ward _____)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Still born infant Wernicke

PERSONAL AND STATISTICAL PARTICULARS

3 SEX not determinable 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single (Write the word)6 DATE OF BIRTH Jan. 25th, 1915
(Month) (Day) (Year)7 AGE _____ yrs. _____ mos. _____ ds. if LESS than 1 day hrs. min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none9 BIRTHPLACE (State or country) St Helena, Balto. Co10 NAME OF FATHER Henry Wernicke11 BIRTHPLACE OF FATHER (State or country) Balto. Co. Md12 MAIDEN NAME OF MOTHER Hilda Ruhe13 BIRTHPLACE OF MOTHER (State or country) Balto. Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hilda Wernicke(Address) St Helena, Balto. Co. Md15 Filed Jan 26, 1915 G. McLinnick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 25, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h. _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born (2 months)
(Duration) _____ yrs. _____ mos. _____ ds.Contributory unknown Self induced
Secondary abortion suspected (Duration) _____ yrs. _____ mos. _____ ds.(Signed) G. McLinnick, M. D.
Jan 26, 1915. (Address) Spontaneous Birth

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Sent to Anatomical Laboratory DATE OF BURIAL _____, 191____20 UNDERTAKER John Hopkins Medical School ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scullie," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recoiler wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 8 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County BaltimoreVillage or City St. Agnes Hospital (No. 102)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mr O Bruce Wheeler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Married

6 DATE OF BIRTH

December 13, 1857
(Month) (Day) (Year)

7 AGE

57 yrs. 1 mos. 6 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)West Virginia

PARENTS

10 NAME OF FATHER

Jacob Wheeler11 BIRTHPLACE OF FATHER
(State or country)West Virginia

12 MAIDEN NAME OF MOTHER

Mary Hammer13 BIRTHPLACE OF MOTHER
(State or country)Do not know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. O. B. Wheeler(Address) Candem Lewis Co. W. Va

15

Filed Jan 19/15 - H. H. Loe

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 19, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec. 16, 1914, to Jan 19, 1915,
that I last saw him alive on January 19, 1915,
and that death occurred on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer or carcinoma,
perforated - local abscess - drained
and per. ant. gastro-astrostomy(Duration) 3 yrs. 1 mos. 6 ds.Contributory
SecondaryStarvation(Duration) 3 yrs. 1 mos. 6 ds.(Signed) Edwin J. Bartlett, M. D.Jan. 19, 1915 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 3 mos. 3 ds. In the State 1 yrs. 1 mos. 6 ds.

Where was disease contracted, If not at place of death?

Former or usual residence Candem, Lewis Co. W. Va

19 PLACE OF BURIAL OR REMOVAL

Weston W. Va.

DATE OF BURIAL

Removed 1-19-15
Jan 21, 1915

20 UNDERTAKER

C. F. Mc Cormick

ADDRESS

1931 W. Fayette St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

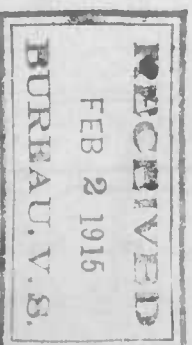
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

408

County Baltimore,Village or City Bay View Asylum(No. 79) CITY HOSPITAL.Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Julia Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Unknown
(Write the word)

6 DATE OF BIRTH 1-860
(Month) (Day) (Year)

7 AGE 55 yrs. 55 mos. 55 ds. OR 1 LESS than 1 day, 55 hrs. 55 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Edward Davidson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mollie (Unknown)

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records
(Address) Bay View

15 Filed Jan 16, 1915 Mrs. Sam Baer
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 15th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from September 21, 1914 to January 15th, 1915.

that I last saw her alive on January 15th, 1915.

and that death occurred on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(Duration) Unknown yrs. Unknown mos. Unknown ds.

Contributory Arteriosclerosis
Secondary (Duration) Unknown yrs. Unknown mos. Unknown ds.

(Signed) M. P. Pincott, M. D.
Jan. 15, 1915 (Address) CITY HOSPITAL.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. 3 mos. 21 ds. In the State 3 yrs. 3 mos. 21 ds.

Where was disease contracted, Unknown

If not at place of death? Unknown

Former or usual residence Unknown

19 PLACE OF BURIAL OR REMOVAL Mt. Auburn DATE OF BURIAL Jan. 18, 1915

20 UNDERTAKER John H. Owens ADDRESS 1722 Division

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

DX

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental poisoning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Baltimore

409

(68)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

32

Village or City

Wt Hope Retreat

(No.)

Wt Hope Md

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ellen Wilson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

Don't Know

(Month)

(Day)

1 (Year)

7 AGE

abt53

yrs.

0 mos.

0 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Ireland

PARENTS

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER

(State or country)

Supposed Ireland
Not Known

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER

(State or country)

Supposed Ireland
Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rebecca Wt Hope Retreat

(Address)

Wt Hope Md

15

Filed

Jan 7, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan6th1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May1890to Jan 6th1915that I last saw her alive on Jan 6th, 1915and that death occurred on the date stated above, at noon m.

The CAUSE OF DEATH* was as follows:

Chronic Dementia (Terminal)abt

(Duration)

27

yrs.

0 mos.

0 ds.

Contributory
SecondaryChr. Septicemiaabt

(Duration)

2

yrs.

0 mos.

0 ds.

(Signed)

Frank J. Flannery

M. D.

Jan 6th

1915

(Address) Wt H

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

27

yrs.

0 mos.

0 ds.

In the

State

27

yrs.

0 mos.

Where was disease contracted, Baltimore (?)

If not at place of death?

Former or usual residence

Baltimore Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral CityJan 7, 1915

20 UNDERTAKER

ADDRESS

Stewart Mowen Co108 W North Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

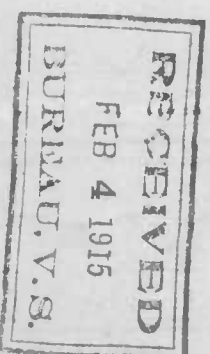
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

County

Baltimore

Village or City

Ruhl

(No.)

St.; Ward)

2 FULL NAME

Albert W. Wineholt

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 35

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Apr. 6, 1851
(Month) (Day) (Year)

7 AGE

63 yrs. 8 mos. 10 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer.

(b) General nature of industry, business, or establishment to which employed (or employer)

9 BIRTHPLACE (State or country)

Pennsylvania

PARENTS

10 NAME OF FATHER

Isacharias Wineholt

11 BIRTHPLACE OF FATHER (State or country)

Unknown.

12 MAIDEN NAME OF MOTHER

Catharine Hemdle

13 BIRTHPLACE OF MOTHER (State or country)

Unknown.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Georgiana Wineholt.

(Address)

Friesland, R.#. 3.

15

Filed

Jan. 5, 1915 - Joseph B. Baldwin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 4, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 13, 1914, to Jan. 4, 1915.

that I last saw him alive on Jan. 3, 1915.

and that death occurred on the date stated above, at 3:40 A.M.

The CAUSE OF DEATH* was as follows:

Malignant Carcinoma,

Internal - O.M.C. (Duration) yrs. 9 mos. ds.

Contributory (Secondary)

Peritonitis,

(Duration) yrs. mos. ds.

(Signed)

J. L. Yagge, M. D.

Jan. 4, 1915 (Address) Mrs. Friesland, Pa.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sleep Cemetery Sleep, Pa. July 6, 1915

20 UNDERTAKER

ADDRESS

Bartendous Monmouth, Buxley Rd

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

411

County BaltimoreVillage or City Canton. (No. 4107, 1st Ave., St.; Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Frank Wlecek,

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mala 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept 9, 1914
(Month) (Day) (Year)

7 AGE 3 yrs. 28 mos. 28 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION None
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Infant,

9 BIRTHPLACE (State or country) Baltimore. Co.

10 NAME OF FATHER Michael Wlecek,
11 BIRTHPLACE OF FATHER (State or country) Austria,
12 MAIDEN NAME OF MOTHER Annie Czechotowska,
13 BIRTHPLACE OF MOTHER (State or country) Austria,

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Michael Wlecek,(Address) 4107. 1st. Ave,

15

Filed Jan. 6 - 1915W. E. McChesneyREGISTRAR W. E. McChesney

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 5, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Senility
Convulsion

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. S. [Signature], M. D.
Jan 6, 1915 (Address) [Address]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Stanislaus. Cemetery DATE OF BURIAL Jan. 7, 1915

20 UNDERTAKER William Fialkowski ADDRESS 1618 Eastern Ave.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

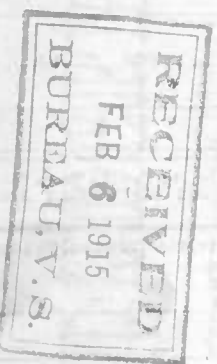
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congedial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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412

1 PLACE OF DEATH

County Baltimore (8)

Village or City Highlandtown (No. 708 S. Third St. St.; _____ Ward)

Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Bernadette Wolf

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|---------------------------------|---|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> |
| 6 DATE OF BIRTH <u>Jan. 22nd, 1915</u> (Month) (Day) (Year) | | |
| 7 AGE _____ yrs. _____ mos. _____ ds. | | 8 If LESS than 1 day. _____ hrs. _____ min. ? |
| 9 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | |

10 BIRTHPLACE (State or country) Baltimore Co.

PARENTS

| | |
|---|---|
| 10 NAME OF FATHER <u>Bernard Wolf</u> | 11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore Co.</u> |
| 12 MAIDEN NAME OF MOTHER <u>Theresa Thamer</u> | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u> | |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bernard Wolf
(Address) 708 S. Third St.

15 Filed Jan. 23, 1915 W.E. McClaughlin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 22, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw him _____ alive on _____, 191____.

and that death occurred on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:
Still born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Signed) A. L. Warner, M. D.
Jan. 23, 1915 (Address) Crover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Jan. 23, 1915

20 UNDERTAKER W. J. Feiler ADDRESS 403 S. Wolfe

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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RECEIVED
FEB 6 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

413

County Baltimore

119

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 32

Village or City Yamson (No. _____, St.; _____ Ward)

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Osborn Hoelf

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH July 21, 1859
(Month) (Day) (Year)

7 AGE 56 yrs. 5 mos. 25 ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Md.

PARENTS
10 NAME OF FATHER Alexander Hoelf
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER Hannah Evans
13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. O. Mose

(Address) Pikesville

15 Filed 1/17/1915 Henry G. May Jr. REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 16, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1915, to July 16, 1915, that I last saw him alive on July 16, 1915.

end that death occurred on the date stated above, at 4.20 a.m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory Indigestion
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. O. Mose, M. D.
July 16, 1915 (Address) Pikesville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Thomas Cem DATE OF BURIAL 1-18, 1915

20 UNDERTAKER Henry W. Jenkins & Sons Co ADDRESS McPulloch & Orchard Sts.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

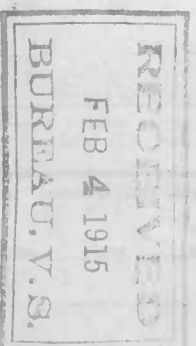
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

414

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 37Village or City Quaker Bottom (No. _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rosie Wright

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH July 4, 1884
(Month) (Day) (Year)

7 AGE 60 yrs. 5 mos. 28 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work General House Work
(b) General nature of industry, business, or establishment in which employed (or employer) Home Work

9 BIRTHPLACE (State or country) Balti. Co. Md.

10 NAME OF FATHER John Shuster

11 BIRTHPLACE OF FATHER (State or country) Balti. Co., Md.

12 MAIDEN NAME OF MOTHER Malinda Little

13 BIRTHPLACE OF MOTHER (State or country) Balti. Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. H. Benson(Address) Croftsville Md.

15 Filed Jan 5, 1915 Dr. H. Benson, J.M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 2, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1913 to Jan 2, 1915, that I last saw her alive on Dec 27, 1914

and that death occurred on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 2 mos. 2 ds.
Contributory General Debility & Heart Failure
Secondary

(Signed) Dr. H. Benson, M. D.
Jan 2, 1915 (Address) Croftsville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Stevenson Burial DATE OF BURIAL Jan 5, 1915

20 UNDERTAKER W. C. Brooks ADDRESS Franklin

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

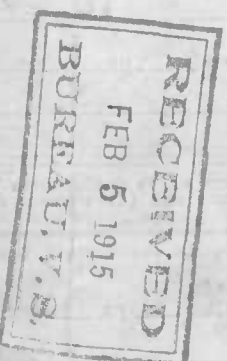
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County BaltimoreRegistered No. 30Village or City Catonsville (No. 154 Rose Ave St; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Elizabeth Keeling Yeatman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH July 11, 1879
(Month) (Day) (Year)7 AGE 85 yrs. 6 mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Va10 NAME OF FATHER Wm. K. Land11 BIRTHPLACE OF FATHER (State or country) Va12 MAIDEN NAME OF MOTHER Eliza Stone13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary B. Meyer(Address) Wilmington N.C.15 Filed Jan 11, 1915 Marshall B Wrist

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 11, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1914, to Jan 11, 1915.that I last saw her alive on Jan 10, 1916.and that death occurred on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age(Duration) yrs. 6 mos. ds.Contributory (Secondary) asthma(Duration) yrs. 1 mos. ds.(Signed) Marshall B Wrist M. D.Jan 11, 1915 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. ds. In the State yrs. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Norfolk VaJan 13, 1915

20 UNDERTAKER

ADDRESS 1944Harry W. Ehler Norfolk Va

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

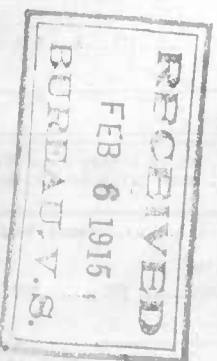
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificate.

1 PLACE OF DEATH

416

County

Baltimore

81

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

33

Village or City

Delight

(No.)

Md

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Comad Yox

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

widow

6 DATE OF BIRTH

Feb 4, 1841
(Month) (Day) (Year)

7 AGE

73 yrs. 11 mos. 6 ds.
If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Germany

PARENTS

10 NAME OF FATHER

John H. Yox

11 BIRTHPLACE OF FATHER
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Catharine unknown

13 BIRTHPLACE OF MOTHER
(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Yox

(Address)

Delight, Md

15

Filed

Jan 11, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 10th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from
Feb 5th, 1913, to Jan 4th, 1915.

that I last saw him alive on Jan 8th, 1915.

and that death occurred on the date stated above, at 1.4 m.

The CAUSE OF DEATH* was as follows:

arterio Sclerosis

(Duration) 1 yrs. 11 mos. 25 ds.

Contributory
Seconda

(Duration) yrs. mos. ds.

(Signed) J. Frank Williams, M. D.

Jan 11, 1915 (Address) Reisterstown, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDE, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dried Ridge Cemetery Jan 12, 1915

20 UNDERTAKER

ADDRESS

J. F. Eline Reisterstown

If more blanks are needed, address State Registrar, 6 N. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

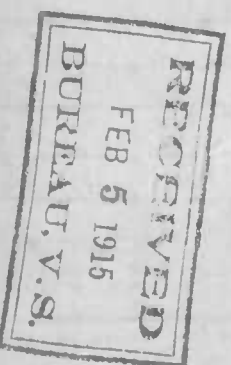
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Balto

417

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Highlandtown (No. 321 S Clinton St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Elizabeth Gappling

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)6 DATE OF BIRTH Aug 12, 1890
(Month) (Day) (Year)7 AGE 24 yrs. 5 mos. 1 ds. If LESS than 1 day, hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) Housework9 BIRTHPLACE (State or country) Baltimore

| | |
|---------|---|
| PARENTS | 10 NAME OF FATHER <u>Julius Gappling</u> |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> |
| | 12 MAIDEN NAME OF MOTHER <u>Mary Schumacher</u> |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Balto</u> |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julius Gappling
(Address) 321 S Clinton15 Filed Jan. 14, 1915 W E McLaughlin
4 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 13, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from April, 1914, to January 13, 1915.that I last saw her alive on January 11, 1915and that death occurred on the date stated above, at 10:10 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) 2 yrs. mos. ds.Contributory
Secondary(Duration) yrs. mos. ds.(Signed) Frank A. Beatty, M. D.
Jan. 14, 1915 (Address) 324 S Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Carol Cemetery Jan 16, 1915

20 UNDERTAKER ADDRESS

J. Harris & Co 2008 Orleans

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state means or injury and qualify as accidental, surgical, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 6 1915
BUREAU, V. S.